Programme Assessment Tool for a Human Rights-Based Approach to Voluntary Family Planning (HRBA to FP)

September 2021
Acronyms

FP            Family planning
FP2020        Family Planning 2020
FP2030        Family Planning 2030
HIV/AIDS      Human immunodeficiency virus/acquired immunodeficiency syndrome
HRBA          Human rights-based approach
ICPD          International Conference on Population and Development
NGO           Non-governmental Organization
SRHR          Sexual Reproductive Health and Rights
UNFPA         United Nations Population Fund
UPR            Universal Periodic Review
WHO           World Health Organization
Acknowledgments

This assessment tool was developed by Jan Kumar, Karen Hardee, Lynn Bakamjian, and Melanie Croce-Galis of the What Works Association, in response to an assessment of the UNFPA human rights-based approach to family planning. The tool benefited from review by UNFPA, notably Ben Light, Jennie Greaney and Emilie Filmer-Wilson, and staff from regional and country offices and from Jill Gay of the What Works Association. Staff from Family Planning 2030 (FP2030) also provided helpful comments on this tool.

© UNFPA September 2021
1. Background

A. Need for this tool

This tool provides practical guidance for assessing family planning programmes through a human rights lens. The *Programme Assessment Tool for a Human Rights-Based Approach to Voluntary Family Planning (HRBA to FP)* creates a foundation for designing or improving client-centred family planning programmes that apply human rights standards and principles at all levels of the healthcare system. It was developed in response to a 2020 study conducted by UNFPA and the What Works Association (WWA) that identified a need for such guidance. The tool is comprised of a framework depicting an ideal programme, an eight-step assessment and planning process, an agenda and all necessary materials for an illustrative stakeholders’ workshop and three templates.

The international community has recognized the intersection of human rights and family planning since 1968 when it declared couples’ basic human right to decide freely and responsibly the number and spacing of their children and the right to related information and education at the Conference on Human Rights in Tehran (United Nations, 1968). A year later they added the right to contraceptives (“the means necessary”) at the United Nations General Assembly. In the ensuing 50-plus years, these rights have been reiterated and embalished in numerous international declarations, covenants and programmes of action, most notably the 1994 United Nations International Conference on Population and Development (ICPD) Programme of Action. This landmark document shifted the focus of family planning programmes worldwide from curbing population growth to advancing the health and human rights of individuals, particularly of women. It made human rights and gender equality explicitly central to the UNFPA mission and called upon governments everywhere to promote human rights in how they design and carry out family planning programmes.

Nearly 20 years after the ICPD, the 2012 London Summit on Family Planning refocused the world’s attention on family planning, raising it as a priority on the global development agenda and inspiring donors and governments to commit to reinvigorating and expanding family planning programmes to serve more women and girls with unmet need. The Summit highlighted ensuring reproductive rights for all, especially for people living in the global South, to guarantee that women and girls in these countries enjoy the same right and freedom to determine if, when and how often they have children as do their counterparts in wealthier countries. The Summit launched the Family Planning 2020 (FP2020) Partnership, which has become a global champion for rights-based family planning.

Globally-agreed goals – both the Millennium Development Goals and the Sustainable Development Goals – have given high priority to achieving universal healthcare and empowering women and girls, and this has galvanized global attention to the importance of protecting and fulfilling individuals’ rights to quality contraceptive information and services and full, free informed choice. Many organizations, including the World Health Organization and UNFPA, now promote rights-based family planning. They and others, including FP2020, the Futures Group and EngenderHealth among them, have issued guidance to explain and operationalize the approach. However, to date there is no consensus on a definition of a human rights-based approach to family planning, and the profusion of guidance documents that have been published tends to confuse rather than clarify the issue. As a result, governments and programmes still struggle with what a rights-based approach to family planning means, and how to apply it.
B. Definition

There is no standard definition of a human rights-based approach to family planning. This tool uses the definition developed for the 2020 assessment of UNFPA’s human rights-based approach to family planning conducted by UNFPA and the What Works Association (UNFPA and WWA, 2020). The definition, shown in Box 1, draws on a range of sources.¹

**Box 1: Definition of a human rights-based approach to family planning**

The human rights-based approach to family planning (HRBA to FP) is a **systematic process** to ensure that attention to **human rights principles** related to family planning is embedded in **all programmatic phases** (i.e. needs assessment, programme design, workplan development, implementation, monitoring and evaluation) at **all levels of the programme** (i.e. policy, service delivery, community and individual).

In 2014, the World Health Organization articulated a set of human rights-related principles and standards that pertain to contraceptive information and services. In 2015, they were elaborated further for family planning programming by UNFPA and the World Health Organization, through FP2020’s *Rights and Empowerment Principles for Family Planning* (FP2020, 2015), which added additional principles to produce the following list (Box 2).² These principles come from international human rights standards established by human rights mechanisms and enshrined in international conventions that states have ratified.

This definition is consistent with UNFPA guidance on HRBA (UNFPA, 2020).

---


2. In addition to agency, autonomy and empowerment, FP2020 highlighted the importance of the principle of equity for family planning, related to non-discrimination. Equity, like equality, is about fairness, and implies that all groups have the same access to quality information, contraceptive methods and services, including removal of contraceptives, and that there are no differences in how they are treated by providers. Equity takes needs into account in order to ensure fairness (e.g. adolescents may need youth-friendly services, and marginalized populations may need mobile services, to assure their access to quality family planning). For a discussion about the importance of equity in family planning see Hardee et al (2019) and Stratton et al (2021).
The principles and standards for HRBA to FP are linked to eight categories of action that can be taken at different levels of the health system to fulfill human rights as described in *Ensuring Human Rights Within Contraceptive Service Delivery: Implementation Guide* (UNFPA and WHO, 2015):

- Ensure access for all (non-discrimination)
- Commodities, logistics and procurement (availability)
- Organization of health facilities (accessibility)
- Quality of care (acceptability, quality, informed decision-making, privacy and confidentiality)
- Comprehensive sexuality education (accessibility)
- Humanitarian context (right to accessible services)
- Participation by potential and actual users (participation)
- Accountability to those using services (accountability)

The aim is to place people at the centre: “Rights-based family planning is driven by the needs and rights of people the programme is meant to serve, rather than the program’s structure, systems, staff or numeric goals” (Kumar et al., 2018: 4).

The goal of this approach is to fulfil the “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children” with access to quality information and services, free from discrimination or coercion (ICPD Programme of Action 1994, para 7.3).

2. **Purpose of this tool**

This is a tool that provides a vision of an ideal, rights-based family planning programme and guides an assessment and planning process. It is not a solution for protecting and fulfilling human rights in family planning programmes in and of itself. Use of this tool is part of an ongoing effort towards the progressive realization of family planning programmes that routinely respect, protect and fulfill the human rights of all individuals. The assessment and action planning are necessary first steps, but they are not sufficient. They require the ongoing support of other efforts and systems.

The tool aims to foster a mindset that encompasses an understanding of rights-based family planning and an awareness of what it looks like in practice; such a mindset colours how people think about and go about their work. Taking a human rights-based approach is not meant to add additional work, but rather to ensure that consideration of human rights and related principles is **intentional, comprehensive and systematic** throughout the cycle of programme planning, implementation, evaluation and improvement. If this seems complex, it is - because good, comprehensive programming is complex, not because it is human rights-based.
The tool serves multiple purposes. It is intended to guide stakeholders responsible for designing and strengthening family planning programmes or broader sexual and reproductive health and rights (SRHR) programmes. The objectives of the tool are to:

- Orient stakeholders to the essentials of human rights-based family planning;
- Guide stakeholders in how to plan and conduct an assessment of the strengths, weaknesses and gaps related to how human rights are protected and fulfilled in family planning programmes or broader sexual and reproductive health programmes;
- Describe how to develop an action plan to strengthen the human rights dimension of family planning programme design and programme improvement;
- Assist stakeholders in evaluating family planning programmes from a human rights perspective, and holding these programmes accountable to the communities and individuals they are meant to serve.

Though this assessment tool can be used alone, whenever possible its application should be incorporated into existing situation analysis processes, e.g. in development of national reproductive health/family planning strategies, family planning costed implementation plans or adolescent health strategies.

3. Intended users

The intended users of this tool are stakeholders responsible for designing and strengthening family planning programmes. This audience includes staff from development partners and technical assistance organizations and their national and sub-national government counterparts, private sector partners and representatives of the community.

4. Components of the tool

The tool is comprised of a framework that depicts an ideal programme, an eight-step assessment and planning process, an agenda and all necessary materials for an illustrative sample stakeholders’ workshop and three templates. It builds upon the definition of a human rights-based approach to family planning (Box 1) and key guidance documents from United Nations agencies including UNFPA and the World Health Organization for human rights-based programming in general and for family planning in particular. It also draws from the Rightsizing Family Planning Toolkit (FP2020, 2018); guidance materials for developing rights-based Family Planning Costed Implementation Plans; a conceptual framework for voluntary human rights-based family planning (Hardee et al., 2014) and the Users’ Guide for the framework (Kumar et al., 2014); and training materials developed for a project in Kaduna, Nigeria supported by Palladium (Palladium and WWA, forthcoming). Finally, the illustrative workshop plan in this tool is modeled on the workshop design from pilot training on human rights-based family planning conducted for the East and Southern Africa Region by UNFPA, World Health Organization and FP2020 in 2015 (UNFPA and WWA, 2020).

This tool is unique in its step-by-step approach that considers all levels of the healthcare system and all applicable human rights principles. It is designed to identify key needs and recommended actions that could be incorporated into other plans (e.g. costed implementations plans) or strategies.
The assessment tool is comprised of the following four components:

A. **Framework**: The graphic framework diagram shows the desired state, i.e. the essential elements of a comprehensive, human rights-based family planning program;

B. **Eight-step process**: The second part is a step-by-step process for engaging stakeholders to assess the status of their programme compared with the desired state, and to develop an action plan to strengthen human rights in family planning;

C. **Workshop plan**: An illustrative sample plan with all support materials is provided for use during a stakeholders’ programme assessment and planning workshop;

D. **Templates**: Three templates provide guidance to the steps in the assessment and planning process.

### A. Framework

The following figure and related levels present the Comprehensive Human Rights-based, Voluntary Family Planning Programme Framework (Hardee et al., 2014). The Framework defines the essential elements that should ideally be in place at the various levels in the healthcare system for a comprehensive, human rights-based family planning programme. Such an ideal programme does not yet exist. It is an aspiration. Yet every programme is somewhere along the continuum that leads to this desired state.

The framework includes a visual overview of a whole programme (Figure 1), plus elaborations that detail what should be in place at each of four levels (Levels 1 to 4):

- Supportive culture and community
- Enabling legal and policy environment
- Quality information and services
- Empowered and satisfied client

Empowered and satisfied clients who can exercise their right to bodily autonomy are at the core. They are surrounded by quality information and services, an enabling legal and policy environment, and a supportive culture and community. When these conditions exist, it indicates that all of the human rights-related principles and standards that pertain to contraceptive information and services are being applied.

It is important to note that any holistic, quality family planning programme can take a human rights-based approach to programming; in other words, the approach is consistent. It makes a focus on human rights intentional in how people go about their work and builds on familiar tenets of quality of care, but does not entail different programming processes.

This framework applies to a national programme that takes a Total Market Approach and includes the stewardship function of the government and the services provided by the public sector, the private sector and non-governmental organizations (NGOs). However, it is equally applicable to programmes that are more limited in scope. Annex 1 shows how rights principles and standards are aligned across the four levels of the framework.

**Figure 1: Diagram of the framework**

---

**THE COMPREHENSIVE HUMAN RIGHTS-BASED, VOLUNTARY FAMILY PLANNING PROGRAMME FRAMEWORK**

- Women, men, adolescents and young people know and demand their human rights
- Sociocultural and gender norms support reproductive self-determination for all, including adolescents and youth
- There is widespread community awareness and knowledge of family planning
- Community-based systems help individuals get the contraceptive information and services they want
- Community members engage in developing, monitoring and holding programs accountable

**Empowering and Satisfied Client**

- The State guarantees that reproductive rights are respected, protected and fulfilled for all without discrimination of any kind
- Legal, policy and programmatic frameworks are aligned with international human rights and service delivery standards
- Adequate infrastructure and resources for family planning information and services are allocated and rationally distributed
- A wide range of contraceptive options is offered
- Effective monitoring and accountability mechanisms and linkages are in place at all levels
- Every individual is treated equally without discrimination
- All individuals exercise agency in making and acting on their own FP decisions through informed choice from among a wide range of contraceptive methods
- Clients are satisfied with services, finding them respectful, culturally acceptable, convenient, affordable and available when needed

**Quality Information & Services**

- Quality contraceptive information and services, including a wide range of methods, are provided equitably to all individuals without discrimination through a range of service models
- Services are provided with neither pressure nor access barriers
- Clients are counseled to make their own informed, voluntary decisions
- Mechanisms are in place to elicit client input and feedback about service delivery and to redress human rights violations
- Program managers and healthcare workers comply with service delivery standards, and understand and meet their responsibilities as rights duty-bearers

"All couples and individuals can decide freely and responsibly the number, spacing and timing of their children, and have the information and means they need to do so, free from discrimination or coercion." — ICPD, 1994

---
Level 1

SUPPORTIVE CULTURE & COMMUNITY

AGENCY/EMPOWERMENT
• Rights literacy is widespread
• Communities recognize that all people, everywhere, are entitled to human rights
• Marginalized groups, in particular women, adolescents and youth, are empowered to realize their sexual and reproductive health and rights
• Women, men and young people have knowledge of FP
• Gender norms support women, adolescents and youth in making and acting upon their own informed FP decisions
• The community supports healthy transitions from adolescence to adulthood
• Civil society is mobilized to advocate for policies, funding and programs that support equitable access to quality FP services

ACCEPTABILITY
• The use of FP by all population groups, including unmarried youth, is culturally acceptable and supported by community and religious leaders

PARTICIPATION
• Community members, including women from marginalized populations, adolescents and youth, are fully engaged in the formulation of policy affecting FP service delivery and in monitoring programs
• Health committees comprised of community volunteers provide a critical link between service facilities and communities

ACCOUNTABILITY
• Community members, including adolescents and youth, participate in program development and monitoring
• Social accountability mechanisms are in place, as are robust means of redress for rights violations

ACCESSIBILITY
• Affordable transportation links individuals to service delivery points
• Community-based distribution of contraceptives enhances access
ENABLING LEGAL & POLICY ENVIRONMENT

NON-DISCRIMINATION AND EQUALITY
• Laws and policies promote and protect access to quality contraceptive information and services for all and equal treatment of all individuals
• The State guarantees that human rights are exercised without discrimination of any kind

AVAILABILITY
• Adequate resources are allocated
• Functioning healthcare facilities, commodities and services exist in sufficient quantity, and are well distributed, offering a wide range of contraceptive options, including client-controlled methods
• Follow-up and removal services exist in both the public and private sectors

ACCESSIBILITY
• Information and services are physically and economically within reach
• Comprehensive sexuality education is provided
• No third-party authorization, unjustifiable medical barriers or other restrictions exist
• Contraceptive security is assured
• The widest range of service providers who can safely provide services is trained and authorized to do so
• Mobile services, community-based distribution and service integration expand access
• Special efforts are made to reach displaced populations and those in crisis settings

ACCEPTABILITY
• A gender perspective is at the center of all policies, programs and services affecting women’s health
• Services are culturally appropriate and sensitive to life cycle requirements

QUALITY
• Service delivery standards meet international norms
• Effective training and HMIS systems are in place
• Healthcare facilities, commodities and services (including skilled medical personnel) are medically appropriate, respectful and comply with approved service standards

INFORMED DECISION-MAKING
• The principle of autonomy, expressed through voluntary, informed decision-making, is embodied in human rights law and protected by client counseling
• Individuals are not subjected to incentives or policies that foster coercive provider practices, nor to non-medical eligibility criteria that create barriers to access

PRIVACY AND CONFIDENTIALITY
• The privacy of individuals’ health information enjoys legal protection

PARTICIPATION
• Women and youth participate fully and are informed and represented in the planning, implementation and monitoring of FP-related policies, programs and services

ACCOUNTABILITY
• The State embraces its role as duty-bearer
• Its legal, policy and programmatic frameworks are aligned with international human rights standards
• Effective monitoring and accountability mechanisms are in place at all levels to ensure that individuals’ agency and choices are respected, protected and fulfilled and to redress rights violations
• Measures of program success are rights-supportive
• Rights-related indicators are included in routine program monitoring
• Systems and structures engage with national human rights institutions (NHRIIs) to monitor state human rights obligations, oversee law enforcement, and engage with international human rights mechanisms to strengthen accountability for SRHR, including engaging in the Universal Periodic Review (UPR) and treaty bodies
• Individuals from all groups, including marginalized populations, are made aware of their rights
QUALITY INFORMATION AND SERVICES

NON-DISCRIMINATION AND EQUALITY
- Quality information and services are provided equitably to all individuals without discrimination of any kind

AVAILABILITY
- The full range of contraceptive methods offered plus removal services for IUDs and implants are supported by adequate supply of commodities and equipment, competent staff and infrastructure
- An effective contraceptive security system prevents stock-outs

ACCESSIBILITY
- Equitable service access is assured for all through various service models (static, mobile, integrated, youth-friendly, plus effective referral) and convenient service delivery points (“leave no one behind”)
- All contraceptive services are affordable
- No non-medical eligibility or third party consent requirements exist

ACCEPTABILITY
- Facilities, commodities and services are acceptable to intended beneficiaries
- Services are provided in an ethical, culturally respectful, confidential manner
- Individual preferences are respected

QUALITY
- Skilled medical personnel:
  - Provide safe and appropriate services that meet accepted standards
  - Provide approved and unexpired commodities and equipment
  - Provide clear and medically accurate information
  - Maintain infection protection and adequate sanitation
  - Protect all clients’ dignity and treat all clients with respect
- Effective monitoring, supervision, quality improvement and HMIS systems are in place

INFORMED CHOICE/DECISION-MAKING
- Individuals can choose from a wide range of contraceptive options
- All clients are informed and counseled to ensure they have accurate, unbiased and comprehensible information that includes common side effects, possible risks and whether or not the method protects against HIV/AIDS
- Clients’ right and ability to make their own choices is respected, protected and fulfilled
- Neither providers nor clients receive incentives for accepting or providing FP or particular methods

PRIVACY AND CONFIDENTIALITY
- Providers protect individuals’ privacy and do not disclose any personal or medical information they receive from clients

PARTICIPATION
- Mechanisms are in place to elicit input and feedback from clients and community members about service delivery

ACCOUNTABILITY
- Program managers and healthcare workers have rights literacy
- As duty-bearers, they respect, protect and fulfill individuals’ human rights
- Managers routinely monitor human rights in their program
- Effective mechanisms are in place to manage alleged and confirmed rights violations
EMPOWERED AND SATISFIED CLIENT

NON-DISCRIMINATION AND EQUALITY
- Very individual is treated the same without discrimination based on who they are, their age or their circumstances

AGENCY/AUTONOMY/EMPowerMENT
- Can make and act on their own FP decisions in consultation with whomever they choose, without pressure or obstacles from the healthcare system, their partner or family

AVAILABILITY
- Offered a broad range of methods and services to choose from

ACCESSIBILITY
- Has correct and understandable contraceptive information and can get services that are physically convenient (through static or mobile services, community-based distribution or effective referral), affordable and available when needed

ACCEPTABILITY
- Methods offered suit their needs and preferences
- Services are respectful and culturally appropriate

QUALITY
- Services and commodities are medically safe and provided respectfully in a clean and comfortable environment

INFORMED CHOICE
- Can decide whether or not to use FP and what method to use, based on accurate and complete information, including side effects

PRIVACY/CONFIDENTIALITY
- Receives information and services in a setting where no one can hear or observe client-provider interactions; records and information are not shared with anyone

PARTICIPATION
- Make their own informed FP decisions and can provide input and feedback regarding how FP services are provided

ACCOUNTABILITY
- As rights-holders, know and claim their human rights
- Speak up if any of their rights are violated, and have access to redress
B. Eight-step process

The assessment and planning process consists of eight steps, as shown in Figure 2.

Figure 2: The process of applying a comprehensive HRBA framework to assess, plan or strengthen family planning programmes

Step 1: Compile key documents including laws, policies, strategies, standards, results frameworks and essential data related to human rights and family planning programmes.

Step 2: Convene representative stakeholders including community leaders, women (including from marginalized populations), youth, policymakers, programme managers, service providers and clients to engage in participatory programme assessment and planning.

Step 3: Establish a common understanding of a human rights-based approach to family planning.

Step 4: Compare the existing programme to the desired state: Use a vision of the desired state as a reference, and refer to the key documents as needed. Go systematically, point by point to identify programme strengths, weaknesses and gaps from a human rights perspective.

Step 5: Identify the challenges: Identify the challenges for each desired programme element that is weak or lacking; conduct a root cause analysis; and identify actionable areas and impediments and tensions that could block necessary action.

Step 6: Set parameters of a plan: Prioritize what programme strengths to expand and what areas to improve. Determine at what level(s) action is required and what actors have authority to act, and identify desired strategic partners.

Step 7: Formulate an action plan: Detail actions, responsible parties, timeframe and monitoring indicators.

Step 8: Link the plan to existing monitoring, evaluation and accountability processes and mechanisms.
Step 1: Compile key documents

The first step in the assessment process is to gather key documents including laws, policies, strategies, results frameworks, guideline and standards that govern human rights and family planning programming and accountability. These documents will be reviewed by stakeholders at the workshop. They will provide a picture of the current status of the legal and policy environment that governs family planning and human rights in the country. These documents are usually listed in existing family planning or reproductive health strategies, e.g. family planning costed implementation plans or national reproductive health policies/strategies. Additional documents related to accountability may be found at the relevant National Human Rights Institution.

This step can be undertaken by a staff member from an organization involved in family planning or a consultant who is knowledgeable about the family planning programme, and if possible, human rights.

If funding and time permit, conduct a desk review to analyse how (and if) the various documents incorporate human rights-based family planning. It can help to extract the wording on human rights from the documents. Given that some programming may be rights-supportive but not mention rights directly, this desk review should be undertaken using the framework of the essential elements of a comprehensive human rights-based family planning programme (Figure 1).

Step 2: Convene representative stakeholders

The next step is to select a total of 30 to 40 diverse individuals who can represent the perspectives of the community, law and policy, service delivery, and individual programme beneficiaries. These individuals should include community leaders, women’s and rights activists, women (including from marginalized populations), youth, policymakers, programme managers, service providers and clients. It is also advisable to include donor representatives. This group will bring their different perspectives to bear in a joint programme analysis and planning process that will be facilitated in the three-day stakeholders’ workshop. See Annex 2 for the workshop agenda.

Step 3: Establish a common understanding

Although human rights is a common theme in development discourse and in healthcare strategies, there is not a common understanding of what a human rights approach means in actual practice in regards to sexual and reproductive health, and specifically to family planning. Therefore, to increase rights literacy and to create a foundation for programme assessment and planning, the first half of the workshop is dedicated to establishing a common understanding among all participants. Participants review the following information:

- What human rights are and which rights apply to sexual and reproductive health;
- How to define/explain a HRBA to FP information and services, how it differs from Quality of Care, and what specific rights and related principles and standards apply to family planning;
- The rationale for taking a HRBA to FP, the value it adds, and the consequences of not respecting and protecting human rights;
- Factors that support and factors that hinder human rights in family planning programmes, as well as common challenges and tensions, drawn from a range of country examples;
- The key elements of a comprehensive programme approach that supports a HRBA to FP.
Step 4: Compare the existing programme to the desired state

What is the desired programmatic state we are all striving for? A vision of this state is depicted in *The Comprehensive Human Rights-based, Voluntary Family Planning Framework*, described above. This provides a basis of comparison between the ideal and the status of the family planning programme under review. The framework details what should ideally be in place for each human rights-related principle that applies to family planning programmes at each level of the healthcare system. Working in small groups that represent the different perspectives of those levels, participants can go point by point to contrast their reality to the ideal to identify strengths, weaknesses and gaps in their programme from a human rights perspective. The documents compiled in advance of the workshop can be referenced to support this activity.

Use the template for Worksheet #1: Identifying programmatic strengths, weaknesses and gaps from a human rights perspective (Annex 3).

Step 5: Identify the challenges

By this step, the programme has been interrogated through a human rights lens and programme weaknesses and gaps with respect to human rights have been identified. It is now necessary to drill down further to get to the underlying root causes of conditions or practices that require improvement. This can be accomplished through a simple root cause analysis. This is done by asking “Why?” each identified factor or condition exists, then asking “Why?” again to get closer to the root of the problem, and then repeating the question at least once more to reach the fundamental issue that has to be tackled to enable the desired programme change. To ensure a feasible plan, it is also important to consider the reality of the context in which programmes and plans exist, and to identify practical impediments and tensions that are likely to challenge required action. Common challenges include cultural and/or political sensitivity over human rights, lack of support for the rights of certain groups (e.g. adolescents and youth), limited resources, the tension between striving for numerical goals versus respecting and protecting individuals’ human rights, balancing cost efficiency with equitable access, and with the need to offer the widest possible range of contraceptive method options.

Use the template for Worksheet #2: Challenges: root causes of weaknesses and gaps, key obstacles (Annex 4).

Step 6: Set parameters of a plan

Given the complexity of comprehensive programming and the very real resource constraints of most programmes, it is necessary to prioritize issues and determine what can and can't be done in the near term. Progress towards the ideal is an ongoing process over time. Before formulating recommended actions, the planning group needs to set parameters for their plan:

- Prioritize what programme strengths to expand and what elements to improve or add;
- Determine at what level(s) action is required;
- Identify what actors have authority to act;
- Clarify what is within and what is beyond their own mandate and capability, how this fits into the big picture, and where strategic partners may be needed;
- Identify what resources are required and what resources can be mobilized;
Identify desired strategic partners who can contribute resources and expertise either through joint action or complementary efforts;

Define the timeline for the group’s action plan (a duration of one to two years is reasonable, with some quick-wins within the first six months).

**Step 7: Formulate an action plan**

Building upon the previous steps, stakeholders can formulate an **HRBA to FP action plan**. The plan can detail concrete tasks and steps to be taken, specify who is responsible for each step, specify the target date for completing each action, and establish what monitoring indicators will be tracked to measure progress towards completion. Actions recommended by young people and actions that can be carried out by young people should be given serious consideration and support, as feasible. Regarding recommended actions, stakeholders need to determine whether the action entail modifying ongoing activities or adding new interventions, and whether they can be conducted within existing resources or if additional resources will be required (what type? how much?). Advocacy efforts to mobilize the political and financial support needed to carry out priority actions should be built into the plan.

Use the template for Worksheet #3: Developing an action plan (Annex 5).

**Step 8: Link the action plan to existing M&E mechanisms**

The stakeholders’ workshop will include a facilitated discussion to identify existing monitoring and evaluation (M&E) and accountability processes and mechanisms that the plan should be linked to, and actions and actors to make the necessary links. Those identified as responsible for making these links will have to take necessary action after the workshop.

The HRBA to FP action plan is not intended to operate separately from existing or planned family planning strategies and plans. In this step, the process indicators identified in the HRBA to FP action plan should be linked and/or cross-referenced with **existing indicators** (e.g. in the FP Costed Implementation Plan) and integrated into **existing M&E systems**. These systems will range from routine health information systems to special studies, including, for example, Performance Monitoring for Action (PMA) studies (www.pmadata.org).

Likewise, the HRBA to FP action plan should be integrated into **existing accountability systems**, with plans for means to monitor rights-based programming, and to identify rights violation and redress them. If relevant accountability mechanisms are not in place, they should be developed as part of implementation of the HRBA to FP action plan. Robust accountability mechanisms will range from social accountability to ensure that communities can hold local authorities and programmes accountable for services (Boydell et al. 2020; Squires et al., 2020) to monitoring through national human rights institutions for reporting to the universal periodic review of the human rights records of all UN Member States. UNFPA has been actively involved in working with National Human Rights Institutions and should be involved in this aspect of accountability for HRBA to FP (UNFPA, 2019; UNFPA, NDa; UNFPA, NDb).
C. Workshop plan

The third component of this tool is an illustrative sample plan for a stakeholders’ workshop for programme assessment and planning. This three-day workshop completes the assessment and planning process. It is designed to achieve the following objectives:

By the end of the workshop, participants will:

1) Be able to define/explain human rights and a HRBA to FP information and services, how it differs from quality of care, and what specific rights and related principles and standards apply to family planning;

2) Be able to explain the rationale for taking a human rights-based approach to family planning, the value it adds, and the consequences of not respecting and protecting human rights;

3) Be able to describe key elements of a comprehensive programme that supports a human rights-based approach to family planning, as well as common challenges and tensions (drawn from country experiences) that hinder those elements;

4) Be able to explain how to monitor human rights in family planning programmes and to hold programmes accountable for respecting, protecting and fulfilling individuals’ human rights;

5) Have identified programmatic weaknesses and gaps from a human rights perspective, and actions that can be taken to address them in order to strengthen human rights in the family planning programme they support.

A detailed sample workshop plan is attached as Annex 2, with worksheet templates in Annexes 3-5, case studies in Annex 6 and resource slides in Annex 7.

Advance preparation for the workshop requires the following:

- Fully orient the workshop facilitators regarding the assessment tool and process prior to leading their first workshop;
- Arrange all meeting logistics, e.g. selecting and inviting participants, setting the date, securing a venue;
- Compile necessary background documents (as noted in Step 1, above);
- Finalize the workshop agenda and methodologies;
- Prepare a workshop evaluation;
- Prepare and photocopy presentations and hand-outs.

---

3 The workshop should ideally be three days; this can be divided among several days, including virtually, as needed.

4 The presentation in Session 4 in the workshop agenda can be used in a stand-alone session outside of the workshop to introduce HRBA to FP and to strengthen rights literacy.
Follow-up after completing the workshop requires several steps:

- Documenting and sharing the action plan and other workshop outputs with participants;
- Following-up and supporting the implementation and monitoring of the action plan.

**D. Three templates**

Three templates are included in the Annex that will help facilitators of the three-day workshop move step by step through the assessment and planning process. The worksheets will be used to document the outputs of small group activities. Templates for the worksheets are found in Annexes 3 to 5:

- Worksheet #1: Identifying programmatic strengths, weaknesses and gaps from a human rights perspective
- Worksheet #2: Challenges: root causes of weaknesses and gaps, key obstacles
- Worksheet #3: Developing an action plan

**5. Questions addressed by this tool**

A series of fundamental questions are asked as part of the HRBA to FP assessment. Table 1 lists the questions and aligns them with the related components of the Programme Assessment Tool.

<table>
<thead>
<tr>
<th>Question</th>
<th>Tool component</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are we striving for?</td>
<td>The framework diagram depicts the ideal human rights-based family planning programme (Figure 1).</td>
</tr>
<tr>
<td>What is the reality?</td>
<td>This tool will help assess the family planning programme’s strengths, weaknesses and gaps from a human rights perspective, following a review of key documents, a workshop agenda and a process for engaging stakeholders.</td>
</tr>
<tr>
<td>What programme strengths can we build upon and expand?</td>
<td>The stakeholders’ workshop and action plan development (Worksheet #1)</td>
</tr>
<tr>
<td>What programme weaknesses and gaps do we need to address and what are their root causes?</td>
<td>The stakeholders’ workshop and action plan development (Worksheets #1 and #2)</td>
</tr>
<tr>
<td>What existing factors hinder the protection and fulfillment of human rights in programmes for sexual and reproductive health, including family planning?</td>
<td>The stakeholders’ workshop and action plan development</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What actions can be taken, by whom, by when?</td>
<td>The stakeholders’ workshop and action plan development (Worksheet #3)</td>
</tr>
<tr>
<td>What indicators can we use to monitor the plan?</td>
<td>The stakeholders’ workshop and action plan development (Worksheet #3)</td>
</tr>
<tr>
<td>What partnerships/alliances are needed to support programme components and enhance resources?</td>
<td>The stakeholders’ workshop and action plan development (Worksheet #3)</td>
</tr>
<tr>
<td>What accountability mechanisms and bodies exist, and how can we link this plan to ongoing processes?</td>
<td>The stakeholders’ workshop and action plan development</td>
</tr>
</tbody>
</table>
References


Annex 1: Essential elements of a human rights-based programme

This table presents the essential elements of a human-rights based programme that should be in place at various levels for a comprehensive voluntary family planning programme. It is organized according to human rights principles and standards.

<p>| Goal: All couples and individuals can decide freely and responsibly the number, spacing and timing of their children, and have the information and means they need to do so, free from discrimination or coercion (ICPD, 1994) |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Human rights principles and standards | Supportive sociocultural norms and community | Enabling legal and policy environment | Quality information and services | Empowered and satisfied client |
| Non-discrimination &amp; equality | | ● Laws and policies promote and protect access to quality contraceptive information and services for all and equal treatment of all individuals ● The State guarantees that human rights are exercised without discrimination of any kind | ● Quality information and services are provided equitably to all individuals without discrimination of any kind | ● Every individual is treated the same without discrimination based on who they are, their age or their circumstances |
| Agency/autonomy/empowerment | ● Rights literacy is widespread ● Communities recognize that all people, everywhere, are entitled to human rights ● Marginalized groups, especially women and girls, are empowered to realize their sexual and reproductive health and rights ● Gender norms support women in making and acting upon their own informed FP decisions | | | ● Can make and act on their own FP decisions in consultation with whomever they choose, without pressure or obstacles from the health care system, their partner or family |</p>
<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>The community supports healthy transitions from adolescence to adulthood</td>
</tr>
<tr>
<td>Civil society is mobilized to advocate for policies, funding and programmes that support equitable access to quality FP services</td>
</tr>
<tr>
<td>Adequate resources are allocated</td>
</tr>
<tr>
<td>Functioning healthcare facilities, commodities and services exist in sufficient quantity, and are well distributed, offering a wide range of contraceptive methods, including client-controlled methods</td>
</tr>
<tr>
<td>Follow-up and removal services upon request exist in both the public and private sectors</td>
</tr>
<tr>
<td>The full range of contraceptive methods offered plus removal services for IUDs and implants are supported by adequate supply of commodities and equipment, competent staff and infrastructure</td>
</tr>
<tr>
<td>An effective contraceptive security system prevents stock-outs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable transportation links individuals to service delivery points</td>
</tr>
<tr>
<td>Community-based distribution of contraceptives enhances access</td>
</tr>
<tr>
<td>Information and services are physically and economically within reach</td>
</tr>
<tr>
<td>Comprehensive sexuality education is provided</td>
</tr>
<tr>
<td>No third-party authorization, unjustifiable medical barriers or other restrictions exist</td>
</tr>
<tr>
<td>Contraceptive security is assured</td>
</tr>
<tr>
<td>The widest range of service providers who can safely provide services is trained and authorized to do so</td>
</tr>
<tr>
<td>Mobile services, community-based distribution and service integration expand access</td>
</tr>
<tr>
<td>Special efforts are made to reach displaced populations and those in crisis settings</td>
</tr>
<tr>
<td>Equitable service access is assured for all through various service models (static, mobile, integrated, youth-friendly, plus effective referral) and convenient service delivery points (“leave no one behind”)</td>
</tr>
<tr>
<td>All contraceptive services are affordable</td>
</tr>
<tr>
<td>No non-medical eligibility or third party consent requirements exist</td>
</tr>
<tr>
<td>Has correct and understandable contraceptive information and can get services that are physically convenient (through static or mobile services, community-based distribution or effective referral), affordable and available when needed</td>
</tr>
<tr>
<td>Acceptability</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
| Quality | Service delivery standards meet international norms | Skilled medical personnel:  
  — provide safe and appropriate services that meet accepted standards;  
  — provide approved and unexpired commodities and equipment;  
  — provide clear and medically accurate information;  
  — maintain infection protection and adequate sanitation;  
  — protect all clients' dignity and treat all clients with respect. | Effective monitoring, supervision, quality improvement and HMIS systems are in place | Services and commodities are medically safe and provided respectfully in a clean and comfortable environment |
<p>| Informed choice / decision-making | The principle of autonomy, expressed through voluntary, informed decision-making, is embodied in human rights law and protected by client counseling | Individuals can choose from a wide range of contraceptive options | All clients are informed and counseled to ensure they have accurate, unbiased and comprehensible information that includes common side effects, possible risks, and whether or not the method protects against HIV/AIDS | Can decide whether or not to use FP and what method to use, based on accurate and complete information, including side effects |</p>
<table>
<thead>
<tr>
<th>Privacy/confidentiality</th>
<th>Participation</th>
</tr>
</thead>
</table>
| • Clients’ right and ability to make their own choices is respected, protected and fulfilled  
• Neither providers nor clients receive incentives for accepting or providing FP or particular methods | • The privacy of individuals’ health information enjoys legal protection  
• Providers protect individuals’ privacy and do not disclose any personal or medical information they receive from clients  
• Receives information and services in a setting where no one can hear or observe client-provider interactions; records and information are not shared with anyone |
| • Community members, including women from marginalized populations and youth, are fully engaged in the formulation of policy affecting family planning service delivery and in monitoring programmes  
• Health committees comprised of community volunteers provide a critical link between service facilities and communities | • Women and youth participate fully and are informed and represented in the planning, implementation and monitoring of FP-related policies, programmes and services  
• Mechanisms are in place to elicit input and feedback from clients and community members about service delivery  
• Make their own informed FP decisions and can provide input and feedback regarding how FP services are provided |
| Accountability | ● Community members, including adolescents and youth, participate in programme development and monitoring  
  ● Social accountability mechanisms are in place, as are robust means of redress for rights violations | ● The State embraces its role as duty-bearer  
  ● Its legal, policy and programmatic frameworks are aligned with international human rights standards  
  ● Effective monitoring and accountability mechanisms are in place at all levels to ensure that individuals' agency and choices are respected, protected and fulfilled and to redress rights violations  
  ● Measures of programme success are rights-supportive  
  ● Rights-related indicators are included in routine programme monitoring  
  ● Systems and structures engage with national human rights institutions (NHRIs), oversee law enforcement, commitments to international treaties and participation in the universal periodic review (UPR)  
  ● Individuals from all groups, including marginalized populations, are made aware of their rights | ● Programme managers and healthcare workers have rights literacy  
  ● As duty-bearers, they respect, protect and fulfill individuals' human rights  
  ● Managers routinely monitor human rights in their program  
  ● Effective mechanisms are in place to manage alleged and confirmed rights violations | ● As rights-holders, know and claim their human rights  
  ● Speak up if any of their rights are violated, and have access to redress |

Annex 2: Stakeholders' workshop for programme assessment and planning

This is an illustrative sample of an agenda for a stakeholder's workshop. Such a workshop is an important part of applying the Programme Assessment Tool for a Human Rights-based Approach to Voluntary Family Planning (HRBA to FP).

Objectives, Agenda and Facilitator Guidance

Duration: 3 days

Objectives:

By the end of the workshop, participants will:

1. be able to define/explain human rights and a human rights-based approach to voluntary family planning (HRBA to FP) information and services, how it differs from quality of care, and what specific rights and related principles and standards apply to family planning.

2. be able to explain the rationale for taking a HRBA to FP, the value it adds, and the consequences of not respecting and not protecting human rights.

3. be able to describe key elements of a comprehensive programme that supports an HRBA to FP, as well as common challenges and tensions (drawn from country experiences) that hinder those elements.

4. be able to identify indicators, systems and processes for monitoring human rights in voluntary family planning programmes, and mechanisms for holding programmes accountable for respecting, protecting and fulfilling individuals' human rights.

5. have identified programmatic weaknesses and gaps from a human rights perspective, and actions that can be taken to address them in order to strengthen human rights in the family planning programme they support.

Agenda:

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>Time</th>
<th>Session objectives/content</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>9:00-10:00</td>
<td><strong>Session 1: Opening session</strong></td>
<td></td>
</tr>
<tr>
<td>Objective:</td>
<td>1. Welcome remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Introductions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Explain why we are here: need and overall training objectives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Clarify participants' values with respect to human rights</td>
<td></td>
</tr>
<tr>
<td>10:00-11:30</td>
<td><strong>Session 2: Human rights and sexual and reproductive health, including family planning</strong></td>
<td></td>
</tr>
<tr>
<td>Objective:</td>
<td>1. Overview of human rights and those that apply to sexual and reproductive health, including FP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Human rights specific to family planning: Overview of WHO's guidelines Ensuring Human Rights in the Provision of Contraceptive Information and Services (2014),</td>
<td></td>
</tr>
</tbody>
</table>

3. Human rights in the UNFPA Strategic Plan, 2022–2025  
4. Human rights in the vision and principles for FP2030

<table>
<thead>
<tr>
<th>Time</th>
<th>Session objectives/content</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:30-12:00</td>
<td>Break</td>
</tr>
</tbody>
</table>
| 12:00-13:00   | **Session 3: Human rights and family planning in practice: country experiences**  
Objectives:  
1. Highlight practical challenges and tensions that commonly hinder the advancement of human rights in programmes for sexual and reproductive health, including FP (including provider values and biases), considering groups that might be most vulnerable to human rights violations (e.g. youth, PLWHIV, migrants)  
2. Discuss strategies for addressing challenges and tensions, including how to fulfill the rights of the most vulnerable  |
| 13:00-14:00   | Lunch                                                                                      |
| 14:00-15:00   | **Session 4: A human rights-based approach to voluntary family planning (HRBA to FP)**  
Objectives:  
1. Share the definition of a human rights-based approach (HRBA) and clarify how it differs from and adds value to quality of care  
2. Explain the rationale for taking an HRBA to FP  
3. Increase awareness of the benefits of supporting and consequences/risks of not supporting an HRBA to FP  |
| 15:00-16:00   | **Session 5: Factors that support and factors that challenge human rights in family planning**  
Objective:  
1. Identify factors at various levels of the healthcare system (community, legal/policy, service delivery, and individual) that support and factors that hinder realization of clients' human rights in family planning programmes  |
| 16:00-16:15   | Break                                                                                      |
| 16:15-17:00   | **Session 6: Report-back and discussion**  
Objectives  
1. Review and synthesize small group outputs and report to the plenary  
2. Highlight the holistic nature of human rights-based programmes  
3. Identify challenges as well as programme strengths to build upon  |
|               | Close Day 1                                                                                   |

*Note: Session 5 is adapted from The RESPOND Project. 2014. Checkpoints for Choice: An orientation and resource package. New York: Engender Health/the RESPOND Project.*

### DAY 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Session objectives/content</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45-9:00</td>
<td>Recap Day 1</td>
</tr>
</tbody>
</table>
| 9:00-10:00    | **Session 7: What does an ideal HRBA to FP look like?**  
Objectives:  
1. Introduce the Comprehensive, Human Rights-based, Voluntary Family Planning Programme Framework  
2. Review the actions and conditions that should ideally be in place at all levels to ensure that all human rights-related principles and standards that apply to family planning are upheld  
3. Create understanding of how to use the framework to incorporate a rights lens in family planning programming  |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session objectives/content</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00-11:00</td>
<td><strong>Session 8: Assess your family planning programme through a human rights lens, identifying strengths, weaknesses and gaps relative to the ideal</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Identify areas of strength to continue or expand</td>
</tr>
<tr>
<td></td>
<td>2. Identify weaknesses or gaps that require action</td>
</tr>
<tr>
<td>11:00-11:15</td>
<td>Break</td>
</tr>
<tr>
<td>11:15-12:45</td>
<td><strong>Rights strength, weaknesses and gaps assessment continued</strong></td>
</tr>
<tr>
<td>12:45-13:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:45-14:15</td>
<td><strong>Session 9: Identify challenges</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Identify root causes of the weak areas and gaps</td>
</tr>
<tr>
<td></td>
<td>2. Identify impediments to action</td>
</tr>
<tr>
<td>14:15-15:30</td>
<td>Break</td>
</tr>
<tr>
<td>15:30-17:00</td>
<td><strong>Session 10: Set plan parameters</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Present and discuss outcomes of small group work</td>
</tr>
<tr>
<td></td>
<td>2. Select priorities to address in the overall plan</td>
</tr>
<tr>
<td></td>
<td>3. Identify lead actors</td>
</tr>
<tr>
<td></td>
<td>4. Identify strategic partners</td>
</tr>
<tr>
<td>17:00</td>
<td>Close Day 2</td>
</tr>
</tbody>
</table>


---

**Day 3**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session objectives/content</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45-9:00</td>
<td><strong>Recap Day 2</strong></td>
</tr>
<tr>
<td>9:00-11:30</td>
<td><strong>Session 11: Formulate an action plan</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Formulate action steps</td>
</tr>
<tr>
<td></td>
<td>2. Identify responsible parties</td>
</tr>
<tr>
<td></td>
<td>3. Set target dates</td>
</tr>
<tr>
<td></td>
<td>4. Formulate monitoring indicators for planned actions</td>
</tr>
<tr>
<td></td>
<td>5. Identify desired linkages to other efforts, strategies (e.g. CIPs) or resources that</td>
</tr>
<tr>
<td></td>
<td>support planned actions</td>
</tr>
<tr>
<td>11:30-11:45</td>
<td>Break</td>
</tr>
<tr>
<td>11:45-13:00</td>
<td><strong>Session 12: Monitoring, evaluation and accountability of human rights in voluntary family planning programmes</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Identify existing M&amp;E systems in the country and programme context</td>
</tr>
<tr>
<td></td>
<td>2. Identify existing accountability mechanisms at different levels in the country and</td>
</tr>
<tr>
<td></td>
<td>programme context</td>
</tr>
<tr>
<td></td>
<td>3. Identify actions and responsible parties for linking this plan to selected M&amp;E and</td>
</tr>
<tr>
<td></td>
<td>accountability mechanisms</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00-15:30</td>
<td><strong>Session 13: Action plan review</strong></td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Present outcomes of the action planning process; invite comments</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>15:30-15:45</td>
<td>Break</td>
</tr>
<tr>
<td>15:45-16:15</td>
<td>Session 14: Resources and tools</td>
</tr>
<tr>
<td></td>
<td>Objective:</td>
</tr>
<tr>
<td></td>
<td>1. Increase awareness of key resources and tools that support</td>
</tr>
<tr>
<td></td>
<td>programming for, implementing and monitoring HRBA to FP</td>
</tr>
<tr>
<td>16:15-17:00</td>
<td>Session 15: Closing</td>
</tr>
<tr>
<td></td>
<td>Objectives:</td>
</tr>
<tr>
<td></td>
<td>1. Reinforce key messages</td>
</tr>
<tr>
<td></td>
<td>2. Invite a sample of participants to identify insights gained and</td>
</tr>
<tr>
<td></td>
<td>ways they can apply what they've learned to strengthen support for</td>
</tr>
<tr>
<td></td>
<td>human rights in their work</td>
</tr>
<tr>
<td></td>
<td>3. Identify next steps for implementing the action plan in</td>
</tr>
<tr>
<td></td>
<td>coordination with, or as part of, related strategies and plans</td>
</tr>
<tr>
<td></td>
<td>4. Closing remarks</td>
</tr>
<tr>
<td></td>
<td>5. Workshop evaluation</td>
</tr>
<tr>
<td>17:00</td>
<td>Adjourn</td>
</tr>
</tbody>
</table>

Based on the agenda above, a facilitation guide provides additional direction for conducting a stakeholder’s workshop.
Facilitation guide

The proposed workshop plan and the support materials provided can be used as is or adapted as needed. It could be broken into modules and carried out over time. Sessions could be adapted, deleted or added to meet specific needs and/or to accommodate time and resource constraints.

Please note that the slides provided in Annex 7 and also available in PowerPoint do not represent complete presentations. They provide essential content, and are intended to be incorporated into slide sets that the facilitator needs to flesh out and tailor to the local context. Invited panelists are expected to develop their own presentations, which should be specific to the programme and context that are the focus of the assessment.

### Session 1: Opening session

<table>
<thead>
<tr>
<th>Session overview and objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
</tr>
<tr>
<td>1. Welcome remarks</td>
</tr>
<tr>
<td>2. Introductions</td>
</tr>
<tr>
<td>3. Explain why we are here: need and overall training objectives</td>
</tr>
<tr>
<td>4. Clarify participants' values with respect to human rights</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facilitator guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Determine who will make the opening remarks and provide them with assistance, if needed, regarding purpose of workshop.</td>
</tr>
<tr>
<td>● There are different options for doing participant introductions, depending on the size of the group and what works best in your context.</td>
</tr>
</tbody>
</table>

### Session 2: Human rights and sexual and reproductive health, including family planning

<table>
<thead>
<tr>
<th>Session overview and objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>This session establishes a conceptual foundation for the workshop. It defines human rights, identifies those human rights that pertain to sexual and reproductive health, and details the rights-related principles that apply specifically to contraceptive information and services. It also provides institutional context for how human rights figure in UNFPA's latest strategic plan and FP2030's vision and principles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide an overview of human rights and those that apply to sexual and reproductive health</td>
</tr>
<tr>
<td>3. Delineate how human rights are embedded in the UNFPA Strategic Plan 2022-2025</td>
</tr>
<tr>
<td>4. Highlight how human rights figure in FP2030's vision and principles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Methodology</th>
</tr>
</thead>
</table>
A panel consisting of three presentations, allowing for up to 20 minutes each, followed by facilitated discussion. The first presenter will address Objectives 1 & 2. The second speaker will address Objective 3, and the third speaker will address Objective 4.

### Facilitator guidance

**Advance preparation:**
For the first presenter, seek a speaker who specializes in human rights and is conversant in the WHO guidelines (2014), FP2020 Rights and Empowerment Principles, and the UNFPA and WHO Implementation Guide (2015). In addition, you will need someone to represent the UNFPA Strategic Plan 2022–2025 and someone to represent the vision and principles of FP2030, for a total of three panelists.

### Suggested content

- See resource slides

### Points to cover/key messages

- All persons, everywhere, possess human rights by virtue of being human.
- Human rights are legal obligations that duty bearers are responsible for respecting, protecting and fulfilling.
- Reproductive rights are a subset of human rights.
- The obligation of progressive realization requires State actors to take immediate action to do whatever they can within existing resources to advance toward the full realization of human rights for its citizens.
- There are specific rights-related principles and standards that pertain to family planning information and services (Box 2).

### Session 3: Human rights and family planning in practice: country experiences

#### Session overview and objectives

This session explores common issues in addressing human rights in programmes for sexual and reproductive health, including family planning, from the perspective of UNFPA country programmes. It is intended to set the stage for the concepts that will be covered in the following sessions regarding a human rights-based approach to voluntary family planning.

**Objectives:**
1. Highlight practical challenges and tensions that commonly hinder the advancement of human rights in programmes for sexual and reproductive health, including family planning (including provider values and biases), considering groups that might be most vulnerable to human rights violations (e.g. youth, PLWHIV, migrants)
2. Discuss strategies for addressing challenges and tensions, fulfilling the rights of the most vulnerable.

#### Methodology

This will be a panel of three presentations of 10 minutes each, followed by a 30-minute facilitated discussion of common challenges and the strategies used to address them. The presentations will be drawn from experiences of government representatives, multilateral or bilateral staff (e.g. UNFPA staff), and implementing partners working on efforts to advance human rights. They will describe the effort, challenges experienced and strategies used to overcome them.

### Facilitator guidance

**Advance preparation:**
Identify speakers who have experience explicitly or implicitly with programmes that are addressing human rights challenges in family planning.

### Suggested content

**Illustrative topics for presentations could include:**

- Supporting equitable access to services – addressing the need for results while balancing the tension between resource constraints and meeting the needs of the hard-to-reach
- Addressing human rights in conservative settings – how to identify and address provider biases, and to talk about human rights with various stakeholders
- Strengthening monitoring and accountability of human rights in sexual and reproductive health services - how to monitor human rights in FP programmes and to work with national human rights institutions regarding accountability and redress
- Balancing ambitious programme goals with attention to informed choice, quality and agency/autonomy
- Addressing human rights abuses in family planning service delivery – how to manage redress without “burning down the house.”

### Points to cover/key messages

- The points to cover or key messages will depend on the presentations selected. Success stories are compelling; however, there is much to learn from programmes that have experienced challenges in addressing human rights in different contexts; in particular, what have been the results from the application of different strategies at the policy and advocacy, capacity-strengthening and service delivery levels to operationalize human rights within FP or other sexual and reproductive health programmes?

---

### Session 4: A human rights-based approach to voluntary family planning (HRBA to FP)

#### Overview

This session explores the rationale for taking an HRBA to FP, including the unique vulnerabilities of human rights principles and standards that family planning programmes experience in implementation (coercion, access barriers and poor quality). The session explores both the overt (easy to see) and subtle (not obvious) vulnerabilities and why it is important to address both sets of challenges. In addition, the session explores how HRBA adds value to programmatic approaches related to quality of care and gender.

**Objectives:**

1. Explain the rationale for taking an HRBA to FP
2. Increase awareness of the benefits of supporting and consequences/risks of not supporting an HRBA to FP
3. Share the definition of a HRBA and clarify how it differs from and adds value to quality of care and gender programming

#### Methodology

The session consists of a slide show presentation and facilitated discussion.

#### Facilitator guidance

Given the large amount of content in this session, the facilitator should consider ways to vary the delivery of information, for example, by having more than one presenter and/or by stopping for Q&A along the way.
Family planning has certain attributes that set it apart from curative services; i.e. it is an elective, preventative service; it is related to sexuality and fertility and encompasses cultural, religious, gender and power issues; and because of population implications, governments set goals for FP use.

Programmes typically believe that they don’t have any human rights problems when there is no visible coercion; however, this is not necessarily true. There can be subtle, less obvious pressures on clients. And more people are affected by access barriers and poor quality than by coercion. Taking a HRBA can address many challenges that affect coercion, access barriers and poor quality.

A human rights-based approach encompasses aspects of quality of care and of gender programming and can be used as a comprehensive programming tool to address these critical issues that affect sexual and reproductive health and rights in a systematic manner.

### Session 5: Factors that support and factors that challenge human rights in family planning

#### Session overview and objectives

In Sessions 5 and 6, participants will consider factors at the programmatic levels of policy, service delivery, community and individual and consider how they support or hinder clients’ human rights in family planning programmes. These factors will emerge from small group work in which participants analyse case studies.

Objectives:

1. Identify factors at various levels (policy, service delivery, community and individual) that support and factors that hinder clients’ human rights in FP programmes.

#### Methodology

This session will be a small group exercise, during which participants will be divided into groups and asked to review a case study of an individual client in a family planning programme and identify the factors that either support or challenges his/her rights.

#### Facilitator guidance

- Select up to three case studies, one for each small group, from the options provided, or develop alternatives of your own.
- Divide participants in small groups (5-8 persons/group depending on the overall number of workshop participants). Request that each group assign a timekeeper, a rapporteur and note-taker.
- Refer participants to handouts. Assign one case study per group; more than one group can address the same case study if there are more groups than case studies. Note: Each case study will take approximately 10 minutes to report to the plenary, so the facilitator should choose the number of case studies to align with the time available.
- Instruct the groups to read their assigned case study and discuss what factors supported or challenged the individual’s ability to exercise his/her human rights. Write one factor per card or sticky note, determine where the factor occurs and place the sticky note on the flip chart for the level indicated (policy, service, community, individual).
Give the groups 45 minutes to complete the exercise and be prepared to report to the plenary in the next session.

Advance preparation:
Create the table below on flipchart paper in advance of the session and display it in front of the room.
This table matches the table on the participant handouts.

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Handouts:
- Case studies with accompanying case study worksheet (Annex 6).

Resources/materials:
- Flip charts and markers, one set for each group.
- Sticky notes or 3x5 note cards and masking tape

Session 6: Report-back and discussions

Session overview and objectives
This session is a continuation of the previous one and includes the “report-back” to the large group in plenary from small group discussions, and a facilitated discussion to share observations and implications for future action.

Objectives:
1. Review and synthesize small group outputs
2. Highlight the holistic nature of rights-based programmes
3. Identify challenges as well as programme strengths to build upon

Methodology
Small group report-back and facilitated discussion of case studies.

Facilitator guidance
- Ask the groups to report to the large group in a plenary session and:
  - Provide a two-minute summary of their case study. (Participants can follow the case studies they were not assigned in the handout).
  - Review their sticky notes/cards at each level of supporting and challenging factors. If multiple groups used the same case study, the subsequent groups can take turns and provide additional factors that were not mentioned by the first group.
- Solicit participant observations in plenary by asking some or all of the following prompts:
  - Invite observations from the group about the activity and the collective outcome:
  - Did anything surprise you? If so, what and why? Is anything familiar about the case study?
  - Are these case studies relevant to the context within which you work?
  - What level appears to require the most attention?
Observe that there are factors at all four levels that support and hinder rights; addressing these complex barriers requires taking a holistic and comprehensive approach.

Acknowledge the supporting factors that should be valued, strengthened and built upon.

Family planning programmes tend to focus on service delivery and to overlook factors at the other levels of the health system that affect human rights.

Programmes need to apply a holistic approach that recognizes both supportive and challenging factors at four levels (policy, service delivery, community and individual).

Session 7: What does an ideal HRBA to FP programme look like?

Session overview and objectives

This session focuses on what is required to put an HRBA to FP into practice. It introduces the Comprehensive Human Rights-Based, Voluntary Family Planning Programme Framework, a conceptual framework that builds on an earlier programmatic framework and expresses human rights concepts and principles articulated by WHO and FP2020 for contraceptive information and services in programmatic language that makes those concepts more concrete.

Objectives:
1. Introduce the Comprehensive, Human Rights-based, Voluntary Family Planning Programme Framework
2. Review the actions and conditions that should ideally be in place at all levels to ensure that all human rights-related principles and standards that apply to family planning are upheld
3. Create understanding of how to use the framework to incorporate a rights lens in family planning programming

Methodology

Present and discuss the framework, highlighting human rights principles and standards for contraceptive information and services, focusing on outcomes at four levels of the healthcare system; namely, enabling legal and policy environment, supportive culture and community, quality information and services, and empowered and satisfied clients.

Facilitator guidance:

Handouts:
- The Comprehensive Human Rights-based, Voluntary Family Planning Programme Framework brief

Suggested content

See slides for related session

Points to cover/key messages

This framework shares common elements with other FP programming frameworks. What is different is that for every level in the framework, the related human rights principles are expressed programmatically. In addition, human rights literacy is embedded within each programme component to ensure that clients and communities (rights-holders) know what they are entitled to and policymakers, programme managers and service providers (duty-bearers) know what they are accountable for. This is the “secret sauce” for operationalizing a human rights-based approach and for achieving the kinds of transformational outcomes that we all want to see.
**Session 8: Assess your family planning programme through a human rights lens, identifying strengths, weaknesses and gaps relative to the ideal**

**Session overview and objectives**

This session is designed to guide a diverse group of stakeholders through a systematic process to assess the status of human rights in their FP programme. The Comprehensive Human Rights-Based, Voluntary Family Planning Programme Framework will be used as the point of reference.

**Methodology**

This will be a small group working session. Instructions are provided on Worksheet #1.

**Facilitator guidance**

- The facilitator will form four small groups, one for each level of the healthcare system, assigning participants to the level they represent (i.e. community, policymakers, service providers and managers, clients and potential clients – including those from vulnerable groups.)
- Instruct each group to select a rapporteur to record the collective outputs of the group.
- Before the session, make sufficient copies of Worksheet #1 for all participants. Review instructions and answer any questions before setting the groups to their task.

**Handouts:**
1. Worksheet #1
2. Copies of the framework brief

---

**Session 9: Identify challenges**

**Session overview and objectives**

This session prepares the way for developing action plans by getting to the actionable root causes of weaknesses and gaps, and identifying likely impediments.

**Objective:**
1. Identify root causes of the weak areas and gaps
2. Identify impediments to action

**Methodology**

This will be a small group working session. Participants will work in the groups to which they were assigned in Session 8. Instructions are provided on Worksheet #2.

**Facilitator guidance**

**Advance preparation:**
Before the session, make sufficient copies of Worksheet #2 for all participants. Review instructions and answer any questions before setting the groups to their task.

**Handouts:**
Worksheet #2

---

**Session 10: Set plan parameters**

**Session overview and objectives**
In this session, all participants will be brought back to plenary to share the outcomes of their small group work. Each group will have 10 minutes to present plus 5 minutes to address any questions. The facilitator will then lead a discussion to identify cross-cutting themes as well as critical issues specific to particular levels of the system, and to reach agreement on priority areas for the overall plan. The group will then discuss who is best positioned to lead specific actions, and what partners could support or supplement planned interventions.

Objectives:
1. Present and discuss outcomes of small group work.
2. Select priorities to address in the overall plan.
3. Identify lead actors.
4. Identify strategic partners.

Methodology
This will be a plenary session with facilitated discussion.

Facilitator guidance
Make sure analysis has gotten to actionable root causes. Prod participants to think further if necessary. Look for commonalities and differences in the group reports. To help set priorities, consider what is most critical, what is easiest to address. Reinforce the concept of Progressive Realization. Discuss who has authority and resources to lead in areas needing improvement. Facilitate a brainstorm about what strategic partners would be good to engage with.

---

**Session 11: Formulate an action plan**

**Session overview and objectives**
In this session, participants will be assigned to new small groups (up to 5), each of which will include representatives of each level of the system. Each group will be assigned one identified rights-related priority. They will be tasked with fleshing out actions and actors at all levels of the programme, timeline, plus monitoring indicators and links. Worksheet #3 will guide this activity.

Objectives:
1. Formulate action steps.
2. Identify responsible parties.
3. Set target dates.
4. Formulate monitoring indicators.
5. Identify desired linkages to other efforts, strategies (e.g. CIPs) or resources that support planned actions.

**Methodology**
This will be a small group working session. Instructions are provided on Worksheet #3.

**Facilitator guidance**
Advance preparation:
Before the session, make sufficient copies of Worksheet #3 for all participants. Review instructions and answer any questions before setting the groups to their task.

**Handouts:**
Worksheet #3
Session 12: Monitoring, evaluation and accountability of human rights in voluntary family planning programmes

Session overview and objectives

This session will focus on how to link monitoring of the new action plan to existing M&E systems and accountability mechanisms. It will begin with two presentations providing an overview of the following content:

- Speaker 1: What relevant M&E systems exist in the country (e.g. public, private or NGO sectors) or within development partner programmes or projects and the extent to which they monitor for service access and quality or human rights?
- Speaker 2: What accountability mechanisms exist for sexual and reproductive health broadly or FP specifically; the roles of public institutions (e.g. National Human Rights Institutions) and civil society?

The panel will be followed by a facilitated discussion that:

- elicits any other relevant M&E systems or accountability mechanisms;
- prioritizes existing systems and mechanisms to link to and identify necessary steps to incorporate the new action plan into ongoing M&E and accountability efforts.

Objectives:
1. Identify existing M&E systems and processes in the country and programme context;
2. Identify existing accountability mechanisms at different levels in the country and programme context;
3. Identify actions and responsible parties for linking this plan to selected M&E systems and accountability mechanisms.

Methodology

Two presentations (one for Objective 1 and one for Objective 2), allowing 20 minutes each for a total of 40 minutes, followed by 35 minutes of facilitated discussion to plan a way forward.

Suggested content

The content for this presentation will be largely context-specific, and so will have to be tailored to the country and subnational administrative unit in which the programme exists. However, suggested slides that cover general content are provided as a resource to adopt or adapt as presentations are developed.

Points to cover/key messages

- To assure that this action plan gets implemented, its process indicators for tracking progress or completion of activities need to be linked to ongoing M&E systems and processes that exist within UNFPA, government administrative units, NGOs and/or projects.
- Family planning programmes need to be held accountable for respecting, protecting and fulfilling human rights at different levels in multiple ways.

Session 13: Action plan review

Session overview and objectives

The purpose of this session is to review the outcomes of the action planning process in previous sessions (assess FP programme strengths, weaknesses and gaps; identify challenges; set plan parameters; formulate a plan; and identify existing M&E and accountability systems and mechanisms that can be used to monitor the HRBA to FP plan).

Objectives:
1. Present outcomes of the action planning process; invite comments;
2. Identify potential barriers to carrying out recommended actions, and strategies to address them;
3. Invite participant reflections on the exercise and the plan they produced.

Methodology
Small group report-back and facilitated discussion in full plenary

Facilitator guidance
● Ask each of the working groups to report to the large group in plenary and summarize the highlights of their work (10 to 15 minutes for each group):
  o What priority issue did your group address?
  o What are the key actions your group recommends to address this issue?
  o Who will lead what action?
  o What key challenges do you envision? How do you propose addressing them?
  o Who are your main strategic partners?
  o How will your recommended actions be monitored?
● After each presentation, invite participants to ask questions and offer reflections on what they heard.
● Following all presentations, facilitate a discussion about how the different group outputs can be pulled together into a cohesive plan. Are all the issue-specific pieces compatible? Synergistic? What modifications, if any, would the group like to make to the overall plan?
● Ensure that the same individual, institution or group is not made responsible for too many activities. Look for what can be done at each level of the healthcare system.

Points to cover/key messages
● HRBA to FP requires holistic and comprehensive programming. Perspectives of stakeholders at all levels provides insight and depth to the planning process.

Session 14: Resources and tools: What resources do you need to design a programme?

Session overview and objectives
This brief session is intended to ensure that participants share a common understanding of key guidance documents and other resources that they should be using in their work.

Objective:
Increase awareness of key resources and tools that support programming for, implementing and monitoring human rights-based family planning.

Methodology
Facilitated brainstorm and circulation of essential documents.

Facilitator guidance
Advance preparation:
● Assemble copies of key documents to circulate

For brainstorm:
Pose the following trigger questions:
● What resource materials do you use when designing a FP programme or programme component?
● What resource materials do you use to develop and to implement an M&E plan for your FP work?

On a flipchart or computer with a projector, document the resources that come up in the discussion. Observe and comment on those that are most/least commonly cited.
Highlight the following key reference documents and share their links on the slide provided. Note that this list is not intended to be an exhaustive list of all relevant documents, but to give participants an idea of available resources. Circulate copies for participants to review:


- **UNCESCR (2016).** *General Comment 22 to Article 12 of the Committee on Economic, Social and Cultural Rights (CESCR) on the Right to Sexual and Reproductive Health.*

- **WHO (2014)** *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations.* Available at: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSm1BEDzkFeovlCuW1a0Szab0oXTdlmnsfZZVQfQejF41Tob4VljeTiAP6sGFQktsae1vlbb0AekmaOwDOWsUe7N8TLm%2BP3HJpxjHySkUoHMa vD%2Fpyfcp3YIzag


**Suggested content**

See slide provided.

**Session 15: Closing**

**Objectives**

1. Reinforce key messages
2. Elicit a sample of participants’ thoughts for ways to apply what they have learned

**Methodology**

In this wrap-up session, the facilitator will reinforce key take-home messages and urge participants to think about how they can apply what they have learned in their work.

**Facilitator guidance**

Prior to the session, review major themes that emerged from the discussions and prepare a summary for whoever is giving the final remarks.
Annex 3: Template for Worksheet #1: Identifying programmatic strengths, weaknesses and gaps from a human rights perspective

This worksheet accompanies Step 4 in the eight-step process. Use this template for recording the outputs of the systematic interrogation of the programme under review through the prism of human rights. It is for documenting identified strengths that can be continued, expanded or modified. It is also for documenting weaknesses and gaps that require attention in order to improve the ability of the programme to protect and fulfill individuals’ human rights (both beneficiaries and potential beneficiaries).

Working in assigned teams, participants will systematically review the list of desired FP programme conditions that should be in place for each human rights-related principle that applies to FP programmes at their assigned level of the healthcare system (insert reference to the graphic or the table). In this way, participants can determine how their programme reality compares to the ideal. They will record the strengths, weaknesses and gaps of their programme in the table below.

Indicate the level of the healthcare system at which this assessment is conducted: ________________________________

<table>
<thead>
<tr>
<th>Human rights principles and standards</th>
<th>Programme strengths: What elements of the desired state are strong in your programme?</th>
<th>Programme weaknesses: What elements of the desired state need to be strengthened in your programme?</th>
<th>Programme gaps: What elements of the desired state are totally absent in your programme and need to be added?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-discrimination &amp; equality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency/autonomy/empowerment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Availability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informed choice / decision-making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Privacy/confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Annex 4: Template for Worksheet #2: Challenges: root causes of weaknesses and gaps, key obstacles

Once Worksheet #1 is completed, transfer all of the identified programme weaknesses and gaps to this worksheet. Add rows if needed. This worksheet is linked to step 5 of the eight-step process.

Next, prioritize the list of items ranking them from 1 to 3, with 1 meaning top priority to be addressed first, down to 3, meaning lowest priority or not feasible to address in the short term. Considerations for ranking should include:

● Most critical issue
● Easiest/hardest to address
● Tensions or impediments that may create barriers to necessary action
● Necessary resources can/cannot be mobilized

Keep in mind that no one entity is likely to be able to address all needs, but that in developing an action plan, strategic partners will be identified to complement the mandates, strengths and resources of different groups.

For each weakness and gap designated as priority 1, get to the underlying root cause(s) by conducting a simple root cause analysis that consists of asking “Why?” that condition exists three times to get to the fundamental source of the deficiency or impediment that you can do something about. Complete the table below to capture outputs of your analysis, which will form the basis of formulating your action plan.

Indicate the level of the healthcare system at which this analysis is conducted _________________________________
Worksheet #2: Challenges (analysis of root causes of weaknesses and gaps; key impediments)
(add rows as needed)

<table>
<thead>
<tr>
<th>Programme weaknesses and gaps</th>
<th>Priority ranking (1-3)</th>
<th>Root causes of top priorities</th>
<th>Recommended actions to address the root causes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Annex 5: Template for Worksheet #3: Developing an action plan

This worksheet is associated with step 7 of the eight-step process. The outputs of the workshop discussions and small group work will be pulled together to develop an action plan for the next one to two years. Start by importing the recommended actions from the last column of Worksheet #2. Break each one down into concrete tasks. Then for each task, specify who will be responsible for taking action, by what target date. Consider whether the action can be completed within existing resources or if additional resources will have to be mobilized. If advocacy is required to enlist additional support, add this as a recommended action. Also note desired partnerships that could complement or supplement this plan, and specify what they could contribute (e.g. resources, complementary mandate, specific expertise). Finally, list process indicators that could be used to track progress towards completion of each planned action.

Add rows as needed.

<table>
<thead>
<tr>
<th>Worksheet #3: Developing an action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(add rows as needed)</td>
</tr>
<tr>
<td><strong>Recommended actions/tasks</strong></td>
</tr>
<tr>
<td><strong>Responsible party(ies)</strong></td>
</tr>
<tr>
<td><strong>Target date for completion</strong></td>
</tr>
<tr>
<td><strong>Desired partnerships/their contributions</strong></td>
</tr>
<tr>
<td><strong>Monitoring indicators</strong></td>
</tr>
</tbody>
</table>

Annex 6: Case studies


Case study #1: Bathsheba

Bathsheba lives in a remote, rural village in a West African country. The village has a population of 1,225 whose healthcare needs are served by one public primary health care centre (PHC) and one chemist. Access to services for modern contraception is limited to injectables. The PHC is staffed by two senior Community Health Education Workers (CHEWs); they have had only basic training in FP consisting of natural methods, short-term methods (oral pills and condoms), and limited training in long-acting methods including injectables and implants. Supply of contraceptive commodities is unreliable. They have had periodic stock-outs of injectable methods over the last six months. They have very little in the way of client education materials. The few existing family planning posters and client leaflets are in English, though most of the women they serve speak only the local language. The supervisor from the district has been encouraging staff to promote implants as part of a campaign to increase the use of long-acting methods and CPR overall by 20 per cent over the next two years. Besides, the supply of implants is more reliable than other methods.

Bathsheba is a 26-year-old mother of four children, three daughters and a son. She lost another son to malaria. She has been using injectable contraceptives since her last child was born a year ago and is reasonably happy with the method. She had used oral contraceptives previously, but she tended to forget to take her pills. As a result, she experienced two unwanted pregnancies, one of which she ended with an illegal abortion that had complications. Bathsheba’s husband is a farmer who struggles to provide for his family. The couple wants to try for one more son, but they want to wait another year.

Bathsheba goes to the PHC one day to get her three-month injection. She waits for an hour in the crowded waiting area and is finally called by the CHEW, who leads her into a small room and offers Bathsheba a seat. The CHEW greets her with a smile and asks why she has come. Bathsheba tells her she has returned for an injection. The CHEW frowns. “We have no injectables just now”, she tells her. “We have run out. The new supplies have not arrived yet and I don’t know when they will come.” The CHEW pauses as she notices concern register on Bathsheba’s face. She thinks of the implant campaign. “I have another method that would be very good for you”, the CHEW offers. “It will protect you for a long time and you won’t have to remember to do anything.” Bathsheba asks what it is like. “Oh, it is very good. I can put it in today and you can leave without worry”, she said. “Put it in where?” Bathsheba asks. “I will examine you and leave it in your upper arm where it will stay until you want to have it removed.” The CHEW tells her. Bathsheba remembers hearing about a method that can move around in your body and cause harm to your health. She is afraid. “No”, she says. “I don’t want that. I will wait and come back when you have the injectable. I will come again soon.” She thanks the CHEW and leaves.
**Small group instructions:**

1. In your small group, discuss what factors in this case study *support* and what factors *challenge* Bathsheba's human rights. Write individual factors on a sticky note or card.

2. For each factor you identify, determine whether it exists at the policy, service delivery, community, or individual level.

3. Select someone at your table to post and explain your notes during the report-back to the large group in a plenary session.
### Illustrative responses to case study #1:

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>District support for FP promotion</td>
<td></td>
</tr>
<tr>
<td>Service delivery</td>
<td>Clinic is staffed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has leaflets</td>
<td>Choice of methods is limited</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Method of choice (injectable) is out of stock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counseling is poor – focus is on positive attributes of implants only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service availability is limited geographically</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Few client materials; none in local language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited training of health workers in FP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of info and materials in clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client has a long waiting time</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Motivated to get contraception</td>
<td>Lack of awareness/understanding of different methods (implants)</td>
</tr>
<tr>
<td></td>
<td>(injectable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Couple is in agreement about fertility intentions</td>
<td></td>
</tr>
</tbody>
</table>
Case study #2: Grace

Grace lives in a small town in an East African country. The local primary health centre offers a range of primary care services, including antenatal care, delivery care, immunization and treatment of minor ailments. The Community Health Officer has been setting monthly performance goals for child immunization and family planning. PHC staff fear that they may be fired if they do not reach the performance goals.

Grace is a 15-year-old student. She lives with her widowed mother and three younger siblings. She has a boyfriend, Gambo, who is pressuring her to have sex. Gambo is six years older than Grace and has had several other girlfriends. He has been very good to her, gives her things and has helped her family. Her mother strongly disapproves of sex before marriage and keeps urging her to wait until she is older before getting involved sexually. But Grace is afraid Gambo will leave her if she does not agree.

Grace’s friend has told her about the PHC where she can get family planning. One day, after a fight with Gambo about denying him sex, Grace decides to go to the clinic. She is nervous, afraid she will meet someone who knows her mother and afraid of what the health worker will do to her.

Grace enters the facility and takes a seat. She sits quietly and looks around the crowded waiting area. There are posters on the wall. One shows a diagram of different family planning methods. One warns about getting HIV from having sex. One is about Clients’ Rights. There are leaflets on the counter, but Grace is too shy to stand up and take any.

While waiting for over an hour, Grace grows increasingly restless. She is considering leaving, but just then hears her name being called. She follows the nurse into a room where four other people are sitting and talking. The nurse seems rushed and unfriendly. She pulls out a form and starts asking Grace questions she is too embarrassed to answer in front of the others. Annoyed, the nurse scolds her that she is too young to be having sex. Grace says that she has changed her mind. Ashamed and angry, she gets up and leaves the clinic. On her way home, she decides to have sex with Gambo that night without protection.

Small group instructions:

1. In your small group, discuss what factors in this case study support and what factors challenge Grace’s human rights. Write individual factors on a sticky note or card.

2. For each factor you identify, determine whether it exists at the policy, service delivery, community, or individual level.

3. Select someone at your table to post and explain your notes when reporting back to the plenary.
### Illustrative responses to case study #2:

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td></td>
<td>Performance goals might pressure providers to push FP</td>
</tr>
<tr>
<td>Service delivery</td>
<td>The clinic has a poster about clients' rights</td>
<td>Overcrowded clinic; long waits to be seen</td>
</tr>
<tr>
<td></td>
<td>Leaflets exist</td>
<td>Clinic staff rushed and unfriendly</td>
</tr>
<tr>
<td></td>
<td>Integrated services available</td>
<td>Provider doesn’t take cue from client about her concern regarding being overheard</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>Gender and community norms</td>
</tr>
<tr>
<td>Individual</td>
<td>Learned about clinic from a friend</td>
<td>Pressure from boyfriend</td>
</tr>
<tr>
<td></td>
<td>Takes action and tries to get contraception</td>
<td>Concern about confidentiality</td>
</tr>
</tbody>
</table>
Case study #3: Lami

Lami lives in a large town in South Asia where a general hospital is located. The hospital offers the full range of modern family planning methods and serves as a referral site for sterilization and for implant removal. The hospital management is prioritizing family planning due to funding received from an international donor organization to increase family planning use, with a focus on promoting long-term contraceptive methods. They have started a new programme that provides information and referral for women visiting different departments in the hospital. They have given the family planning staff refresher training and they have upgraded the family planning clinic.

Lami is 18 years old and has a baby daughter. She is the junior wife of a truck driver who is away much of the time. Lami knows that when he is not home with her or his other wife he stays with other women. She and her husband are Muslim. He believes that family planning is against their religion. He wants his young wife to bear him as many children as God provides and hopes for sons. Lami had a difficult pregnancy that ended in a Cesarean delivery. While she is conflicted about going against her religion, she is very afraid of getting pregnant again. She has been avoiding relations with her husband as much as possible since her daughter was born six months ago, but is running out of excuses and he is running out of patience with her. She has decided to obtain a family planning method she can hide from him.

Lami goes to the family planning clinic at the hospital. The recently renovated waiting room is clean and cheerful. The walls are lined with posters, showing different contraceptive methods. Before waiting very long, Lami is called by the nurse and is led into a small, private room where she is offered a seat. The nurse smiles and asks why she has come. Lami tells her she has never used contraception, but wants to start to use a method that will give her good protection against pregnancy and that she can keep secret from her husband. She has been pregnant once and experienced complications that she does not want to go through again. The nurse tells her she could use oral pills, an injectable contraceptive or an IUD without her husband’s knowledge or cooperation. There is also the implant, but he could detect this in her arm. The nurse tells her how each method works. Lami wants long-term protection, so she chooses the IUD. The nurse tells her to come back when she has her next period to have one inserted. She gives her a leaflet about the method and sends her home.

Small group instructions:

1. In your small group, discuss what factors in this case study support and what factors challenge Lami’s human rights. Write each individual factors on a sticky note or card.

2. For each factor you identify, determine whether it exists at the policy, service delivery, community, or individual level.

3. Select someone at your table to post and explain your notes during the report-back to the plenary.
### Illustrative responses to case study #3

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Programme focus on long-term methods</td>
<td></td>
</tr>
<tr>
<td>Service delivery</td>
<td>Full range of methods offered, including implant removals</td>
<td>Client asked to come back when she has her period – missed opportunity for contraception</td>
</tr>
<tr>
<td></td>
<td>Provider skills are being updated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clean facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information available</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Client interested in contraception and protection against STIs</td>
<td>Client has religious concerns about FP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Husband/partner having relations with other women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Concerns about husband opposition to FP</td>
</tr>
</tbody>
</table>
Case study #4: Geeta

Geeta is a 28-year-old housewife with three daughters, aged 4, 3 and 6 months. Her last delivery was by Caesarian section. Feeling overwhelmed with the childcare responsibilities of three young children, she does not want to get pregnant in the foreseeable future. Now that she is weaning the baby, she is growing worried that this could happen. Her husband, still disappointed that the last child was a girl, is talking about trying again for her to bear him a son. Geeta is not ready, but she does not stand up to him. “If God wills”, she demurs. She wants to wait two or three years before planning another child. A friend has told her that an IUD would provide long-term protection against pregnancy, and that her husband wouldn’t even have to know she has one. Geeta decides that is what she wants.

Her husband takes her and the baby to the maternal and child health and family planning clinic for a well-baby check. He joins her to meet with the nurse. The nurse is friendly and kind. She confirms that the baby is on a good growth track. They talk about weaning and introducing food to the diet. She gives the baby the vaccination she is due for and reminds them of the schedule for her remaining inoculations. Then she turns to Geeta, “Is everything good with you?” Geeta smiles shyly. “No problem”, she says. The nurse then asks the couple what they are doing about family planning. Before Geeta can respond, her husband chimes in. “I had wanted a boy,” he says. “We want to try again for a son.”

The nurse engages with Geeta’s husband, smiling reassuringly. “Your wife is young and strong. Once the baby is weaned, her fertility will return. You can try whenever you like.”

Geeta sits frozen in silence. She is angry that the nurse did not ask what she wants, but is afraid to contradict both this authority figure and her husband. She leaves the clinic without contraception.
### Illustrative responses to case study #4

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy</strong></td>
<td>FP is integrated with maternal and child health</td>
<td></td>
</tr>
<tr>
<td><strong>Service delivery</strong></td>
<td>The clinic offers couples counseling</td>
<td>Nurse does not communicate with wife to explore her reproductive health needs and fertility desires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse defers to husband; does not offer wife an option to discuss her needs in private</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client not provided information about healthy birth spacing</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Knowledge about FP and different methods in the community</td>
<td>Community norms favour high fertility and male offspring</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>Client is motivated to obtain a method</td>
<td>Lack of empowerment by wife to manage her own fertility desires; husband’s desires take priority</td>
</tr>
</tbody>
</table>
Case study #5: Rose and Doris

Rose lives in a small, rural farming village. Things have been difficult in the village for the past several years, as the crops have been poor because of the drought. Most families live on subsistence farming and nutrition is generally poor. Rose’s village is 25 km away from the nearest health centre and is connected by mainly dirt roads. A new health centre is being built near to Rose’s village, but construction has stopped because funding has run out.

Rose is a 31-year-old mother of four children. Her youngest child is six weeks old. Her last pregnancy was difficult and she lost a lot of blood during labor and delivery. Rose is happy to have a healthy, baby girl, but she is much more tired than she remembers being after her prior pregnancies, making it difficult to work on the family farm. Rose has decided she does not want to have any more children.

Doris, a community health worker, is responsible for conducting home visits under the supervision of the local health centre’s nurse-midwife. She received training several years ago about how to conduct health promotion activities, with a focus on maternal and newborn care. The training included a short module on family planning during this training, consisting mainly of messages about the importance of spacing births and the use of the Lactational Amenorrhea Method (LAM). However, there has been no opportunity for refresher training. Things are difficult at the health centre, as there has been constant staff turnover over the past few years and Doris is on her third supervisor in two years.

Rose receives a home visit from Doris for the six-week postnatal check-up. After conducting the physical check-up, Doris asks Rose about how breastfeeding is progressing, and reviews the importance of maternal nutrition and hygiene. She also reviews the baby's immunization schedule. Rose raises the topic of family planning and asks Doris what she can do to stop having any more children. Doris tells Rose that she will be fine as long as she continues to breastfeed as this will protect her from getting pregnant. Rose is confused, as she became pregnant with her new baby while breastfeeding her toddler. Doris tells Rose that she thinks it is not good to use contraception while the baby is still breastfeeding as it might harm the baby's health. "It's very complicated; it's better if you come to the clinic to ask the nurse-midwife about what to do," Doris says. Rose is concerned, as she is not sure when that will be possible.
### Illustrative responses to case study #5

<table>
<thead>
<tr>
<th>Level</th>
<th>Supporting factors</th>
<th>Challenging factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Health system offers home visits for health promotion</td>
<td>Training emphasis is on maternal and newborn care, but lacks strong family planning component; missed opportunity to fully integrate FP in maternal and child health promotion and service delivery</td>
</tr>
<tr>
<td></td>
<td>Training is conducted for community health workers</td>
<td>No refresher training offers to ensure continuous education and capacity of Community Health Workers (CHWs)</td>
</tr>
<tr>
<td>Service delivery</td>
<td>CHW has good interpersonal skills</td>
<td>CHW does not have skills and confidence to counsel in FP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHW provides inaccurate information about breastfeeding and return to fertility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access is constrained by geographic distance; missed opportunity for services by visiting CHW</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Client is clear about her fertility intention to limit; wants more information</td>
<td>Method offered to client (LAM) not acceptable to her</td>
</tr>
</tbody>
</table>
Annex 7: Resource slides for workshop sessions

These slides are available as a PowerPoint file.

Country Assessment Workshop
A Human Rights-Based Approach to Voluntary Family Planning

Annex 3: Resource Slides

Note about the slides

• The slides provided do not represent complete presentations. They provide essential content and are intended to be incorporated into slide sets that the facilitator needs to flesh out and tailor to the local context.

• These slides include material for sessions:
  • Session 2. Human Rights and Sexual Reproductive Health, Including Family Planning
  • Session 4. A Human Rights-Based Approach (HRBA) to FP
  • Session 7. What Does an Ideal Human Rights-based, Voluntary Family Planning Programme Look Like?
  • Session 12: Monitoring & Evaluation and Accountability of Human Rights in Family Planning
  • Session 14: Resources and Tools

• Invited panelists are expected to develop their own presentations.
Note about the slides

- These slides include material from:

- Slides that are taken directly from another source include that citation on the slide

Session 2: Human Rights and Sexual and Reproductive Health

Resource slides
What are human rights?

- Fundamental entitlements and protections that all people, everywhere, possess by virtue of being human
- Human rights are based on international consensus found in treaties, conferences, documents, and declarations
- They are legal obligations with the status of international and domestic law
- Individual human dignity is at their core

Duty bearers and rights holders

- **Duty bearers**: State and other non-state actors who have an obligation to respect, protect and fulfill human rights and can be held accountable for their actions
- **Rights holders**: Every individual, be it man, woman or child, of any race, ethnic group or social condition
- To some extent groups: e.g., Indigenous Peoples entitled to collective rights
- Every rights holder can make legitimate claims of duty-bearers to meet their obligations

- **Respect** = refrain from interfering with or curtailting the enjoyment of human rights
- **Protect** = guard against human rights abuses
- **Fulfill** = take action to facilitate and promote human rights
Examples of human rights related to health/reproductive health

- **Right to the highest attainable standard of health**
  Governments have the legal obligation to provide health services that are available, accessible, acceptable, and of high quality.

- **Right of couples to decide freely and responsibly the number and spacing of children**

- **Right to sexual and reproductive health services, information, and education**

- **Right to equality and nondiscrimination**

What are reproductive rights?

- A constellation of existing civil, political, economic, social and cultural rights contained in human rights instruments as they relate to:
  1. Freedom to make **reproductive choices** (information and means to do so)
  2. Right to the highest attainable standard of **sexual and reproductive health**
  3. Freedom from **discrimination, coercion and violence**

(ICPD, PoA para. 7.3)
What are reproductive rights?

These rights have also been categorized by Erdman and Cook:

1. Right to **reproductive self-determination**, including:
   - The right to bodily integrity and security of the person and the rights of couples and individuals to decide freely and responsibly the number and spacing of children

2. Right to **sexual and reproductive health services, information and education**, including:
   - The right to the highest attainable standards of health

3. Right to **equality and non-discrimination**, including:
   - Right to make decisions concerning reproduction free of discrimination, coercion and violence


---

Sexuality and reproductive rights

The human rights of women include their **right to have control over and decide freely and responsibly on matters related to their sexuality**, including sexual and reproductive health, **free of coercion, discrimination and violence**.

(Beijing Platform of Action, 1995, para. 96)
Obligation of Progressive Realisation

“Each State Party undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights by all appropriate means ...”

(International Covenant on Economic, Social and Cultural Rights, Article 2)

✓ Recognizes political and cultural constraints
✓ Acknowledges that resources are limited
✓ Lack of resources is not a justification for inaction
✓ Progress needs to be made over time and show results

Obligations of immediate effect

States must take immediate action, irrespective of the resources, in four areas:

1. elimination of discrimination
2. obligation to “take steps”
3. non-retrogressive measures
4. minimum core obligations
Reproductive and human rights related to FP

“These (reproductive) rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so. The principle of informed, free choice is essential to the long-term success of family planning programmes.” ICPD, 1994

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Beijing Women’s Conference, 1995

Reproductive and human rights related to FP

- “States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes the right to control fertility.
- The right to decide whether to have children, the number of and spacing of children
- The right to choose any method of contraception
- The right to self-protection and to be protected against STIs and HIV/AIDS
- The right to be informed on one’s health status and the health status of one’s partner
- The right to FP education
- States responsible for taking all appropriate measures to provide adequate services and information.”

Maputo Protocol on the Rights of Women in Africa, Article 14
Definition of a human rights-based approach to voluntary FP

The human rights-based approach to family planning (HRBA to FP) is a systematic process to ensure that attention to human rights principles related to FP is embedded in all programmatic phases (i.e. needs assessment, programme design, workplan development, implementation, monitoring and evaluation) at all levels of the programme (i.e. policy, service delivery, community and individual).

Source: UNFPA and What Works Association, 2021

Human rights and related principles and standards for FP

<table>
<thead>
<tr>
<th>Principles &amp; Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability</td>
</tr>
<tr>
<td>Accessibility</td>
</tr>
<tr>
<td>Availability</td>
</tr>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Privacy and Confidentiality</td>
</tr>
<tr>
<td>Accountability</td>
</tr>
<tr>
<td>Informed decision-making/informed choice</td>
</tr>
<tr>
<td>Non-discrimination &amp; Equality</td>
</tr>
<tr>
<td>Participation</td>
</tr>
<tr>
<td>Agency, Autonomy &amp; Empowerment</td>
</tr>
</tbody>
</table>
WHO guidance and recommendations

Purpose: to provide guidance for policymakers, managers, providers and other stakeholders in the health sector on some of the priority actions needed to ensure that different human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services.

(Published in 2014)

WHO/UNFPA Implementation Guide

Purpose: This Guide is a companion document to the WHO Guidelines. It sets out core minimum actions that can be taken at different levels of the health system, and provides examples of implementation of the recommendations in the WHO guidelines. It is addressed to midlevel policymakers and managers/implementers involved with FP service provision in all settings.

(Published in 2015)
Human rights and related principles for FP

Definitions of rights principles related to SRH services, information and education

<table>
<thead>
<tr>
<th>Rights Principles</th>
<th>Program Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>• Broad choice of FP methods offered</td>
</tr>
<tr>
<td></td>
<td>• Sufficient number and needs-based distribution of functioning service delivery points</td>
</tr>
<tr>
<td>Accessible</td>
<td>• FP information available in language/term(s) people can understand</td>
</tr>
<tr>
<td></td>
<td>• Geographic access, financial access, policy access</td>
</tr>
<tr>
<td></td>
<td>• Continuous contraceptive services; convenient service hours; service integration increases access</td>
</tr>
<tr>
<td>Acceptable</td>
<td>• Community/family supports women's right to choose</td>
</tr>
<tr>
<td></td>
<td>• Tolerance of side effects</td>
</tr>
<tr>
<td></td>
<td>• Client satisfaction with services</td>
</tr>
<tr>
<td>Quality</td>
<td>• Clinical quality/technical competence</td>
</tr>
<tr>
<td></td>
<td>• Good client-provider interactions and counseling</td>
</tr>
<tr>
<td></td>
<td>• Privacy, dignity, respect demonstrated in service delivery</td>
</tr>
<tr>
<td></td>
<td>• Continuity of care</td>
</tr>
<tr>
<td>Privacy and confidentiality</td>
<td>• Client interactions cannot be observed or heard by anyone else without the client's consent</td>
</tr>
<tr>
<td></td>
<td>• Client records are not shared with anyone and information is not disclosed</td>
</tr>
</tbody>
</table>
### Definitions of rights principles related to reproductive self-determination and empowerment

<table>
<thead>
<tr>
<th>Rights Principles</th>
<th>Program Implications</th>
</tr>
</thead>
</table>
| Agency, autonomy and empowerment | - Women/men/young people have knowledge of FP  
- Women/men/young people know and demand their human rights  
- Client’s ability to make and execute their own decisions without pressure or barriers from system, husband or family  
- Informed, voluntary decision making supported  
- Client-controlled methods offered  
- Supportive gender norms exist in the community |
| Informed decision-making/Informed choice | - Decision whether to use FP and what method to use is made voluntarily, based upon accurate information and understanding, and a range of options to choose from, without barriers or coercion |

### Definitions of rights principles related to equity and non-discrimination

<table>
<thead>
<tr>
<th>Rights Principles</th>
<th>Program Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-discrimination &amp; Equality</td>
<td>- Equal access to quality information and services for everyone (inclusive for age, ethnicity, class, caste, urban/rural/economic/marital status, other vulnerable groups) without bias: fairness</td>
</tr>
</tbody>
</table>

Note: Related to non-discrimination, FP2020 also highlighted the importance of the principle of equity in its rights and empowerment principles. Equity takes needs into account in order to ensure fairness (e.g., adolescents may need youth-friendly services, and marginalized populations may need mobile services, to assure their access to quality FP.)
### Definitions of rights principles related to participation and accountability

<table>
<thead>
<tr>
<th>Rights Principles</th>
<th>Program Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>- Communities and individuals are engaged in planning and monitoring programs</td>
</tr>
<tr>
<td></td>
<td>- Mechanisms exist for community members and clients to provide input and feedback about services</td>
</tr>
<tr>
<td>Accountability</td>
<td>- Clients’ choice and rights are built into staff performance expectations and appraisals</td>
</tr>
<tr>
<td></td>
<td>- Choice and rights routinely monitored; mechanism in place to investigate and remedy allegations of confirmed violations</td>
</tr>
</tbody>
</table>

### Note for UNFPA Participants

- UNFPA produced guidance on applying a HRBA to programming (2020)
- Builds on recommendations from the ICPD Beyond 2014 International Conference on Human Rights
- Identifies three key areas where action is needed in order to operationalize the human rights-based dimensions of the ICPD: Equality, Quality and Accountability.
- For FP, addressing the 10 rights from WHO (2014) and FP2020 (2015), and the UNFPA & WHO implementation guide (2015), is consistent with and supplements this guidance.
Suggested issues for discussion:

- Can human rights be easily discussed in your country context?
- Do/can you use rights terminology or is it more acceptable to address rights in more concrete programmatic language?
- What is the level of rights awareness among different groups of stakeholders (rights holders and duty-bearers) in your country?
- What are the greatest barriers to advancing human rights in your country?
- Does civil society actively promote and protect human rights in your country?

Session 4: A Human Rights-Based Approach (HRBA) to FP

Resource slides
What makes FP unique as a healthcare issue that makes human rights so important?

- FP is an elective, preventative healthcare service
- It is related to sexuality and fertility, which has religious and cultural sensitivities, gender and power dynamics
- Because it has population implications, governments set goals for FP use


FP is vulnerable to rights violations – Coercion, barriers and quality problems

*Coercion* in FP = actions or factors that compromise individual autonomy, agency, or liberty in relation to contraceptive use or reproductive decision making through force, violence, intimidation, or manipulation

*Access barriers* prevent many people—particularly the underserved, hard to reach, unmarried youth—from getting the contraception they want

*Poor quality*, including lack of respect for client’s dignity, privacy or confidentiality; inadequate counseling; substandard clinical care
### FP vulnerabilities: Overt and subtle

<table>
<thead>
<tr>
<th>Overt – what you see</th>
<th>Subtle – less obvious</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coercion</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Poor Quality</strong></td>
<td></td>
</tr>
</tbody>
</table>


### FP vulnerabilities – coercion

<table>
<thead>
<tr>
<th>Overt</th>
<th>Subtle</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Involuntary sterilization of ethnic minorities, the poor, HIV+ individuals</td>
<td>• Incentive payments to providers or clients</td>
</tr>
<tr>
<td>• PPIUd without consent</td>
<td>• Targets or quotas</td>
</tr>
<tr>
<td>• Withholding benefits for non-acceptance</td>
<td>• Community/family pressure</td>
</tr>
<tr>
<td>• Refusal to remove IUD or implant</td>
<td></td>
</tr>
</tbody>
</table>


### FP vulnerabilities – Barriers

<table>
<thead>
<tr>
<th>Overt</th>
<th>Subtle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers</strong></td>
<td><strong>Provider bias against specific method or use by a particular group (i.e., young, unmarried clients)</strong></td>
</tr>
<tr>
<td>Limited choice of methods available (e.g., not offered, stock-outs)</td>
<td>Misinterpretation of eligibility criteria for method use</td>
</tr>
<tr>
<td>Lack of equitable distribution of facilities/service outlets</td>
<td>Lack of accurate information</td>
</tr>
<tr>
<td>Lack of trained providers</td>
<td>Lack of community or spousal support for method use</td>
</tr>
<tr>
<td>Costly, unaffordable services</td>
<td>Unsupportive gender norms/low status of women</td>
</tr>
</tbody>
</table>

### FP vulnerabilities – Poor quality

<table>
<thead>
<tr>
<th>Overt</th>
<th>Subtle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poor Quality</strong></td>
<td><strong>Provider bias regarding specific methods/client populations</strong></td>
</tr>
<tr>
<td>Harried or rude providers</td>
<td>Inadequate referral mechanisms for meeting clients’ SRH needs</td>
</tr>
<tr>
<td>Lack of functioning equipment</td>
<td>Lack of feedback mechanisms to hold facility staff accountable to clients and community</td>
</tr>
<tr>
<td>Poor infection prevention</td>
<td>Poor supervisory system</td>
</tr>
<tr>
<td>Lack of trained, capable providers with up-to-date clinical and counseling skills</td>
<td></td>
</tr>
<tr>
<td>Crowded facility</td>
<td></td>
</tr>
<tr>
<td>Lack of space for private and confidential consultations</td>
<td></td>
</tr>
</tbody>
</table>
FP vulnerabilities – Overt and subtle

<table>
<thead>
<tr>
<th>Coercion</th>
<th>Overt</th>
<th>Subtle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary sterilization of ethnic minorities, the poor, HIV individuals</td>
<td>• Incentive payments to providers</td>
<td>• Incentive payments to providers</td>
</tr>
<tr>
<td>PP/IOU without consent</td>
<td>• Targeting or quotas</td>
<td>• Communitybased contraception</td>
</tr>
<tr>
<td>Withholding benefits for non-acceptance</td>
<td>• Refusal to remove IUD or implant</td>
<td>• Refusal to remove IUD or implant</td>
</tr>
<tr>
<td>Coercion</td>
<td>• Limited choice of methods available (e.g., not offered, stock-out)</td>
<td>• Inadequate knowledge or counseling of specific method or group (i.e., poor, HIV individuals)</td>
</tr>
<tr>
<td>Barriers</td>
<td>• Lack of equitable distribution of service outlets</td>
<td>• Refusal to accept referral or treatment of non-acceptance criteria</td>
</tr>
<tr>
<td>Poor Quality</td>
<td>• Lack of trained providers</td>
<td>• Refusal to provide information</td>
</tr>
<tr>
<td></td>
<td>• Costly, unaffordable services</td>
<td>• Lack of community or spousal support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unsupportive gender norms/low status of women</td>
</tr>
</tbody>
</table>

A rights-based approach can address each of these challenges.

Added value of HRBA to FP “business as usual”

- Business as usual
  - Availability
  - Accessibility
  - Acceptability

- HRBA “added value”
  - Quality
  - Informed decision-making
  - Privacy & confidentiality
  - Non-discrimination & Equality
  - Agency & autonomy
  - Participation
  - Accountability
Gender-integrated programming and HRBA programming – Common ground

- **Common roots**: Both are rooted in sociocultural norms
- **Common goal**: Empowerment to make and act upon one’s own reproductive health decisions for reproductive self determination
- **Common principles**: equity, autonomy/agency, participation

Why take a human rights-based approach?

- Governments have a *legal obligation* to protect and fulfill the human rights of their citizens
- **Benefits to clients**, particularly the vulnerable and marginalized. A HRBA goes beyond quality to ensure that everyone is treated equally, able to get the information and services they want, receive good medical care, be treated with respect, and achieve better health
- **Benefits to programmes and communities**: greater community engagement and trust, better health outcomes, improved family welfare
An HRBA to voluntary FP requires a systematic process:

- Examine *laws and policies* through a human rights lens; identify barriers to rights; advocate for reform to incorporate rights-related principles and protections

- Systematically integrate rights principles into *programme design, service delivery standards and protocols*

- Incorporate rights indicators into *performance expectations* and routine *monitoring*

- Engage communities and individuals in *planning and monitoring programmes*

- Strengthen *accountability* and *redress* mechanisms

**Session 7: What Does an Ideal Human Rights-based, Voluntary Family Planning Programme Look Like?**

*Resource slides*
Applying the framework

- This framework can be *used to design, assess, strengthen, monitor and/or evaluate* FP programmes through a human rights lens

- It offers a *vision of the ideal that provides a reference* against which to compare an existing programme

- Identified *programmatic strengths and areas needing improvement* can inform plans, which can then be implemented, monitored and evaluated
Applying the concept of progressive realization

- Recognizing that:
  - The status of human rights varies among (and within) countries and FP programs
  - Political, cultural, and resource constraints may hinder some elements of a rights-based approach
- Governments and partners should *take whatever steps possible* to advance the protection and fulfillment of human rights in their FP programmes *over time*
- *Lack of resources is no excuse*

Session 12: Monitoring & Evaluation and Accountability of Human Rights in Family Planning

Resource slides
M&E for HRBA to Voluntary FP – What Indictors?

- What process indicators are needed to measure progress in the action plan?
  - At four levels: community, legal & policy, service, client
- Are there indicators in existing M&E plans you could link to?
- What additional indicators could be added to an existing plan?

Some useful resources:
- Monitoring human rights in contraceptive services and programmes, WHO, 2017
- FP2020 core indicators on rights and empowerment, on FP2020 website
- Rights indicators in: The National Composite Index for Family Planning (NCFP), Avenir Health
- Chapter on measurement of rights in FP in Contributions of FP2020 in advancing Rights-based Family Planning
- Also see organizations’ FP M&E Plans

M&E for HRBA to Voluntary FP – What M&E System?

- What existing M&E system/plan could the indicators for this action plan be incorporated into? (E.g., RH/FP strategy, FP Costed Implementation Plan, organization strategy, project M&E plan)
- What indicators would be included in routine monitoring vs. evaluation or special studies?
- Have stakeholders been engaged in identifying and defining indicators?
- What actions would be needed?
- Who should be responsible?
- What will be the process of review and program adjustment?
National Human Rights Institutions (NHRIs)

➢ A national human rights institution, or national human rights commission, is an independent institution bestowed with the legal mandate to broadly protect, monitor and promote human rights in a given country.

➢ Accredited NHRIs that meet United Nations standards:
  • Protect human rights, including receiving, investigating and resolving complaints, mediating conflicts and monitoring activities.
  • Promote human rights through education, outreach, training, capacity building etc.

NHRI Country Assessments

➢ Country assessments can be used to realize NHRIs’ monitoring and protection mandate:
  • Raising awareness of the human rights situation
  • Raising concerns on existing legislation or practice
  • Promoting a human rights-based approach to national development strategies, policies and budgets;
  • Providing inputs to International Human Rights Mechanisms: UPR, TBs and SPs
  • Being the basis for a national inquiry
NHRI National Inquiries

A public national inquiry is a transparent, public investigation into a systemic human rights problem in which the general public, expert stakeholders, including government and civil society, are invited to participate. National inquiries are supported by the powers given to the NHRI in law.

The Kenyan Experience

- Complaint filed by the Federation of Women Lawyers and CRR on systematic violation of women’s reproductive health rights.
- Violations were found under:
  - Family planning: most Kenyans who want it do not have access to it;
  - Maternal health: lack of maternal health services, physical access;
  - Sexual violence: lack of one-stop facilities, difficulty in accessing documents;
  - Sexual and reproductive health rights of sexual minorities: criminalization of homosexuality and prostitution;
  - Sexual and reproductive health rights of marginalized groups: IDPs, refugees, people living with HIV/AIDS, persons with disabilities, adolescents and youth.
Levels of accountability and related mechanisms

**Community:** social accountability mechanisms (particularly promoting participation of youth and other marginalized groups), e.g., social audits, health facility complaint procedures, community-based monitoring, civil society organizations, media

**Local/National:** judicial accountability (courts, tribunals); quasi-judicial (NHRIs); parliamentary commissions; administrative mechanisms; political and legislative processes; professional associations; civil society organizations

**Regional:** judicial accountability (regional courts and human rights mechanisms (e.g. African Regional Commission on Human and People’s Rights), tribunals, parliamentary resolutions)

**International:** Universal Periodic Review of the Human Rights Council, Treaty Bodies (including CEDAW, CRC, CESCIR, etc.), and Special Procedures

---

Session 14: Resources and Tools

Resource slide
Key Resource Documents